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JOURNAL OF THE IOWA MEDICAL SOCIETY | JANUARY 1994

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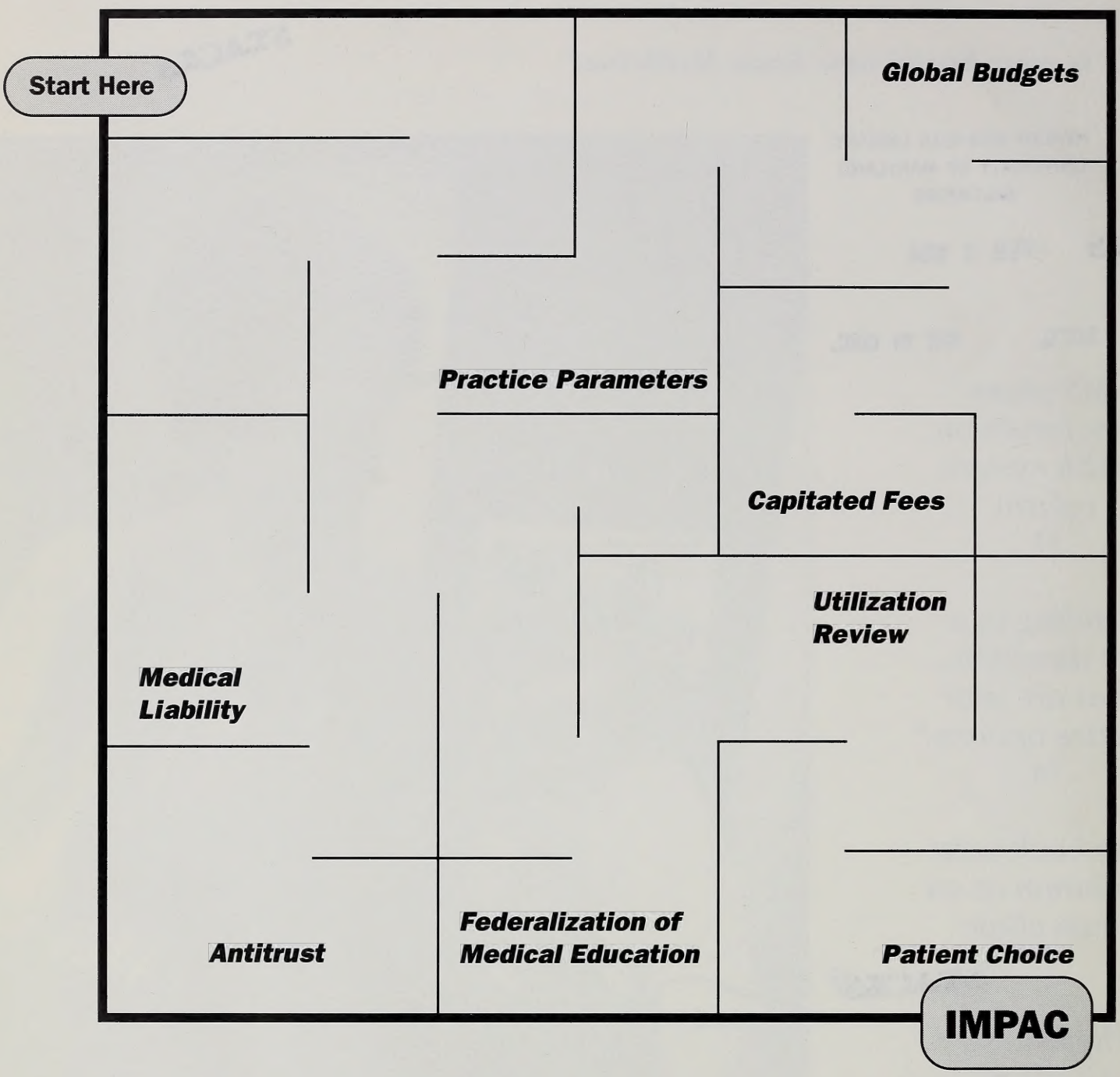
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THE HEALTH SYSTEM REFORM MAZE

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Iowa Medicine

JANUARY 1994 / VOLUME 84 / 1



About the Cover

Therese Halbur, MD, a pediatrician with McFarland Clinic, Ames, keeps this young patient smiling during a wellness check.

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EDITORIAL

7 **The stakes are high in this brand new year**

Health system reform will be the top IMS priority this year, but no individual physician can afford to be a spectator in this game

● *THE PRESIDENT COMMENTS*

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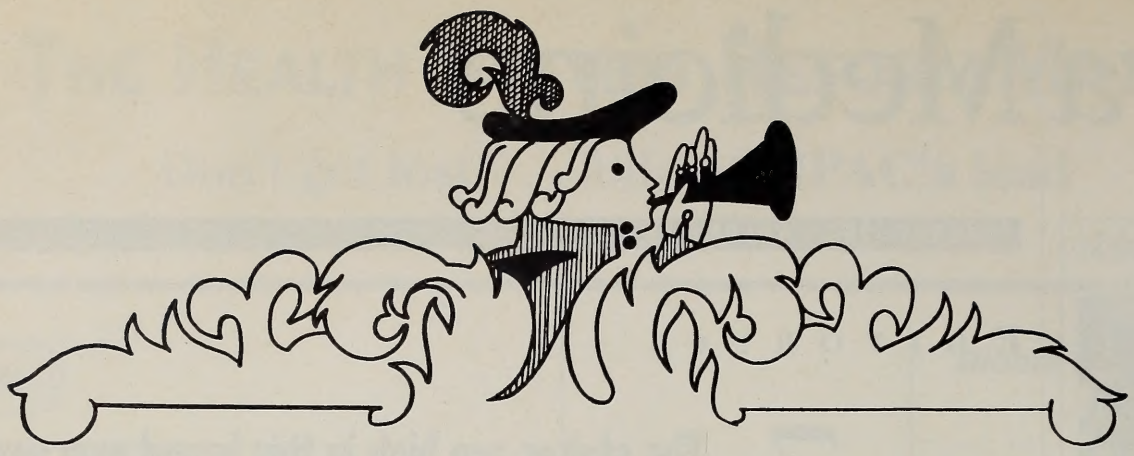
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Announcing!

The first issue of your "new" *Iowa Medicine* . . . redesigned and redefined to better meet your needs.

A message from the IMS president

I invite you to take a look at what your "new" journal has to offer.

Dear Colleague:

Welcome to the inaugural issue of the newly redesigned *Iowa Medicne.*

As the practice of medicine has changed, the information needs of Iowa physicians have also changed. As specialty societies assumed a key role in providing scientific information, IMS used newsletters as a way to increase focus on the socioeconomic and legislative issues which are so vital to Iowa physicians.

In mid-1992, the IMS Strategic Planning Committee on Communications and Image was assigned the task of determining the best way to meet our members' needs.

Our committee, aware of severe limits on physicians' time, decided a more effective plan would be to incorporate all the information into a single publication. The committee recommended a redesign of *Iowa Medicine* which would allow us to present socioeconomic information but retain a format for publishing scientific articles submitted by Iowa physicians. This redesign was approved by the 1993 House of Delegates.

For this month only, *Iowa Medicine* is also being sent to nonmember physicians to demonstrate the valuable benefits available to Iowa Medical Society members.

In closing, I thank the other members of the IMS Strategic Planning Committee on Communications and Image—Dr. Peter Wallace, Dr. Jon Gibson, Dr. Peter Reiter and Dr. Ronald Roth—who together inspired this project.

I hope you enjoy the all new *Iowa Medicine* and that it serves your needs.

J R Anderson MD

John Anderson, MD

Feature Article



24 **Heading in a new direction**

With or without health system reform, managed care is proliferating. Read about your practice options in this totally new environment ● *Thomas Gorey, JD*

Science and Education

29 **Low back pain resolution**

Low back pain is the second leading cause of work absenteeism. The authors discuss management of patients with low back pain seen during one month in an Iowa clinic
● *Sheila McGuire, DMSc; Daniel McGuire, MD*

31 **Trisomy 22 in an Iowa newborn**

This rare clinical syndrome causes multiple malformations. Usually associated with advanced maternal age, this case involved a 16-year-old mother ● *Sergio Golombek, MD; Robert Shaw, MD*

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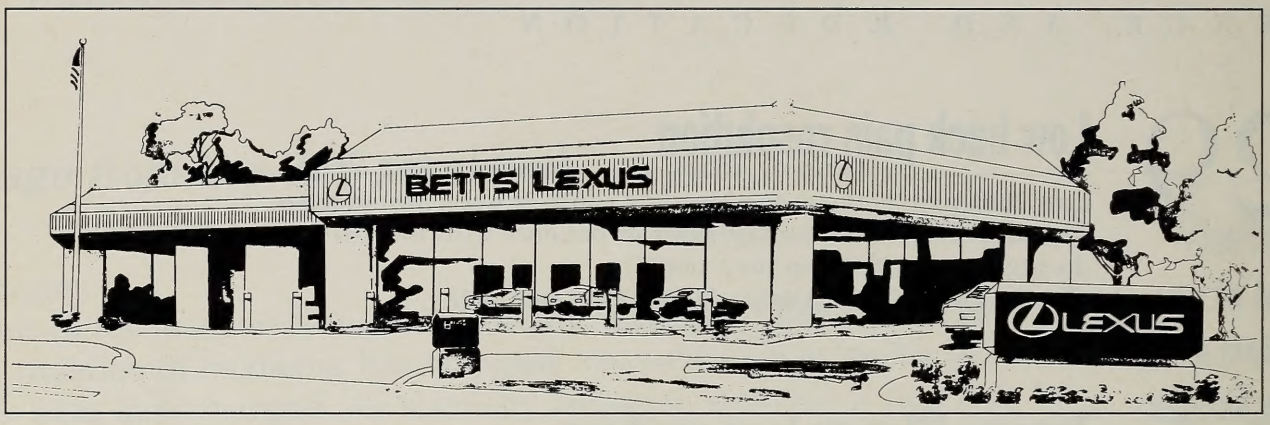
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Iowa Medicine



About the Cover

Radiation oncologist Richard Deming, MD, of Mercy Hospital Medical Center in Des Moines, is assisted by Jeanna Gustafson as he works with a patient undergoing cancer treatment.

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Not all physicians understand how the Board of Medical Examiners disciplinary function works . . . and why it's so important.
● *THE PRESIDENT COMMENTS*

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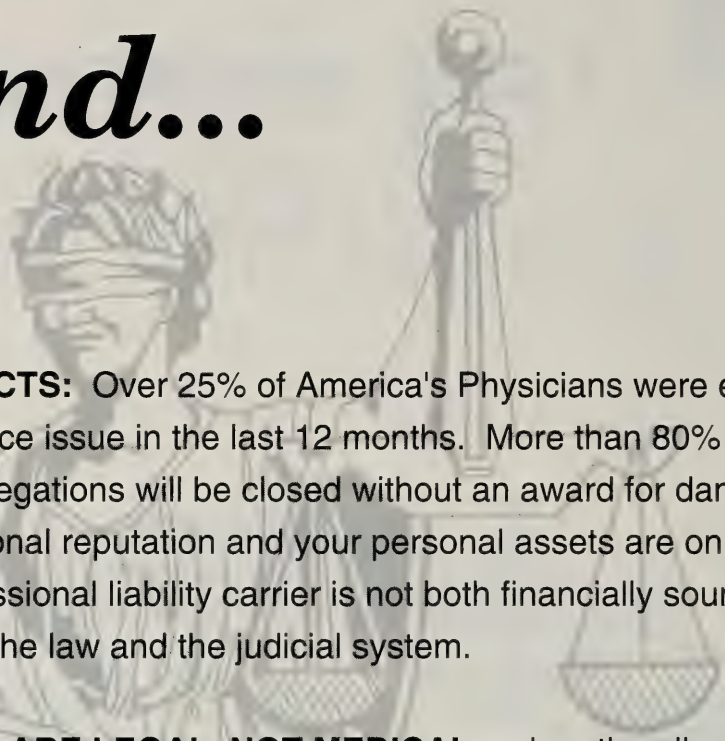
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...a promise to defend...



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FEATURE ARTICLE

68 **CHMIS . . . a Mixed Message for physicians**

Will a Community Health Management Information System be beneficial for Iowa patients and physicians? The answer depends on many factors, says this physician, chairman of the IMS Committee on CHMIS. ● *TERRENCE BRIGGS, MD*



Demand for data gave birth to CHMIS

What is CHMIS and what started it? Opinion leaders believe it will reduce administrative costs of health care delivery and the Iowa Legislature is expected to pass it into law.
● *TIMOTHY GIBSON, IMS STAFF*

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73 **Update on local anesthetics**

The authors review clinical uses of local anesthetics and review adverse reactions. A new topical anesthesia is discussed.
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Four years ago, the Iowa Medical Society endorsed a *Workers Compensation Insurance Safety Group* program underwritten by the Farm Bureau Mutual Insurance Company.

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If yours is one of the 90-plus offices and clinics insured by the Farm Bureau Safety Group program, you will have received a dividend certificate similar to the one shown below. ***Join the program this year,*** and your office will also receive such a certificate.

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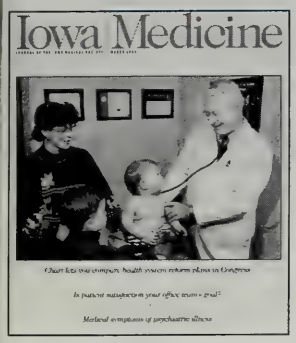
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Iowa Medicine

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About the Cover

Wayne Rouse, MD, a family practice physician with McFarland Clinic in Boone, gets acquainted with a young patient while mom and older brother look on.

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95 **A solicitation for your support**

The IMS Education Fund is in the business of helping people and deserves our support.

● *THE PRESIDENT COMMENTS*

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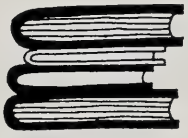
2 WAYS

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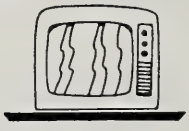
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Talk to all your colleagues every day about health system reform.



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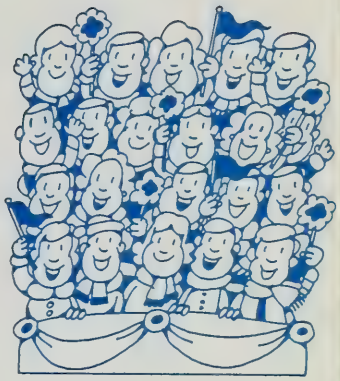
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A tear-out registration card can be found in this issue of *Iowa Medicine*.

Feature Article

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Every member of your office team is important in creating satisfied patients. Patient satisfaction is something to be consciously courted . . . never taken for granted. ● *William Walsh*



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Performing a psychiatric differential diagnosis will often be beneficial for physicians whose patients have unexplained medical symptoms.
● *William Yates, MD*

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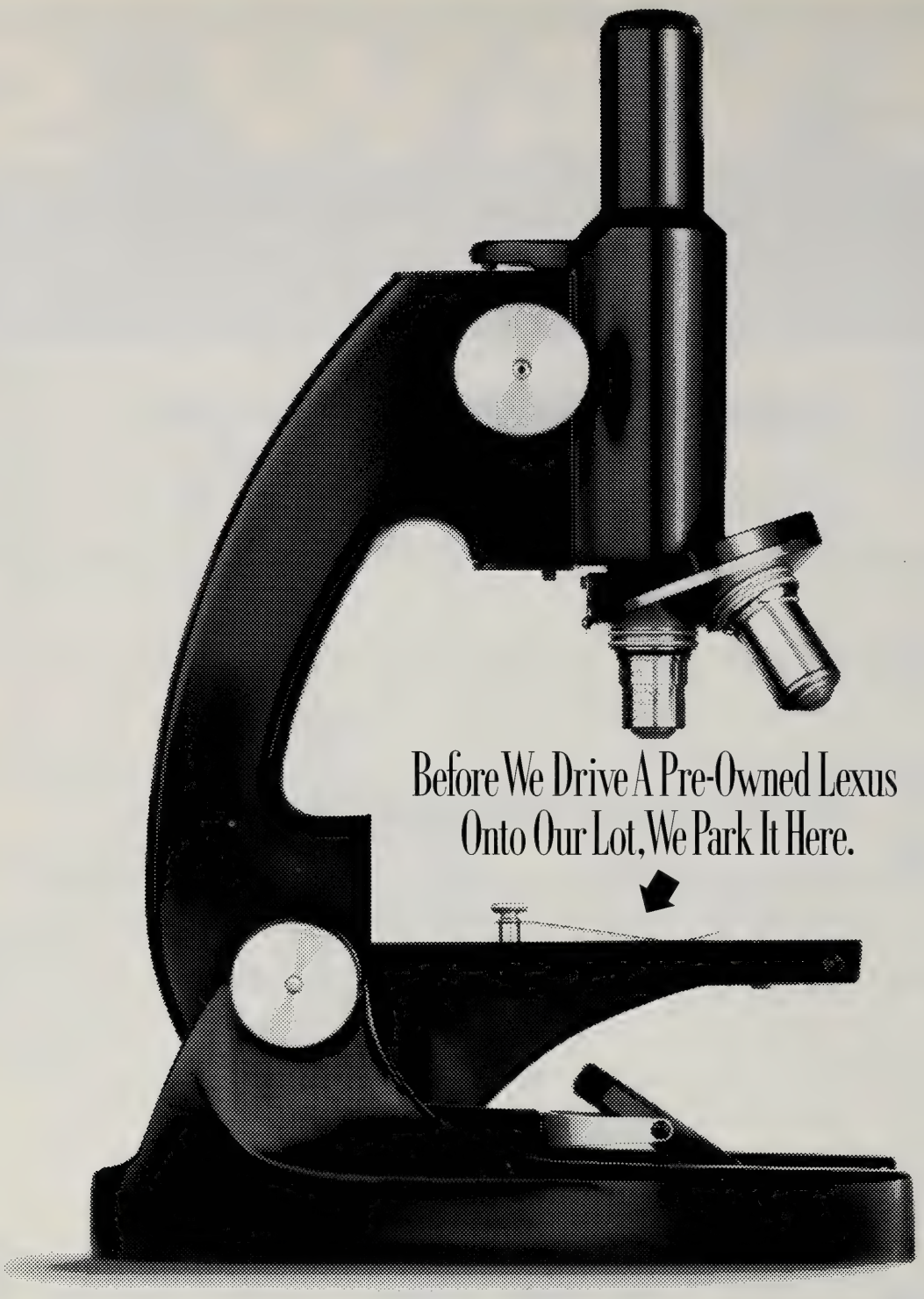
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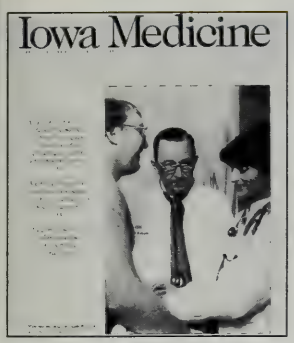
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About the Cover

William Galbraith, MD, associate in the Department of Internal Medicine at the U of I College of Medicine, works with first-year resident Kiran Ahuja and patient David Ungerer. Photo by Jeffory Goetz

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The IMS needs as many physician viewpoints as possible in the debate over health system reform. ● *THE PRESIDENT COMMENTS*

Speak with one voice **Page 145**

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Teamwork achieves success **Page 147**

Membership in the Iowa Medical Society makes you part of the family of physicians, says this urology professor with the U of I College of Medicine. ● *BERNARD FALLON, MD*

What about the needs of your patients? **Page 169**

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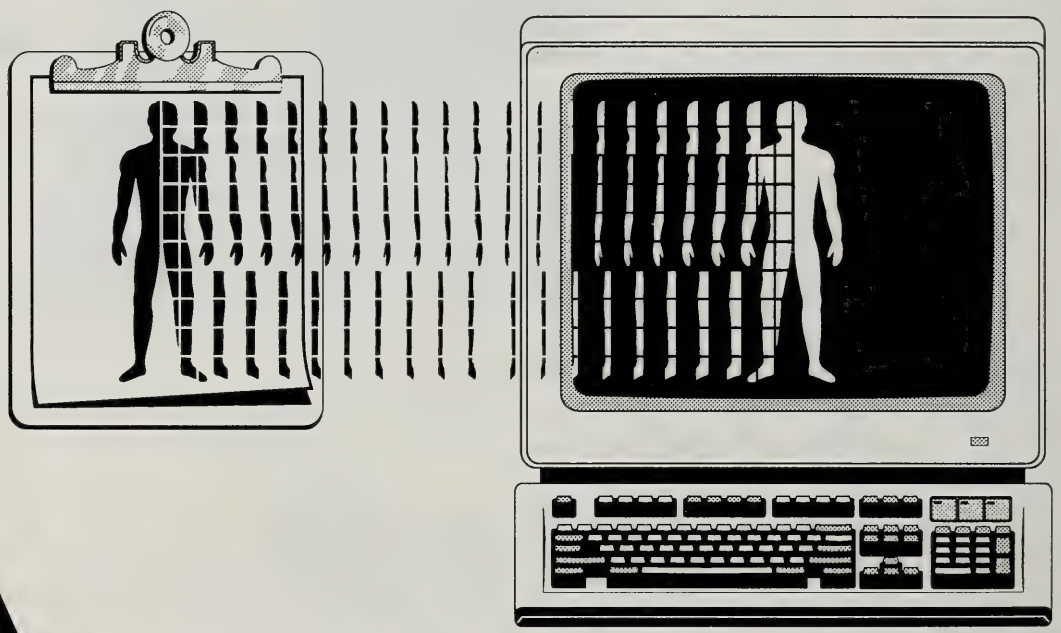
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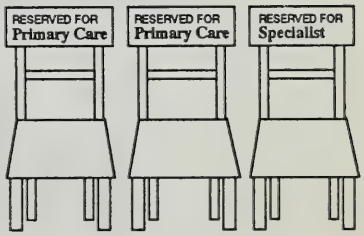
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Health system reform could intensify the growing pressure on medical schools to produce more primary care physicians.
● *RICHARD NELSON, MD*



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Genetic research is not really far removed from everyday practice.
● *PROVIDED BY THE U OF I HEALTH SCIENCE RELATIONS DEPARTMENT*

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An interesting historical account of the importation of Hansen's Disease into Iowa. ● *RICHARD CAPLAN, MD*

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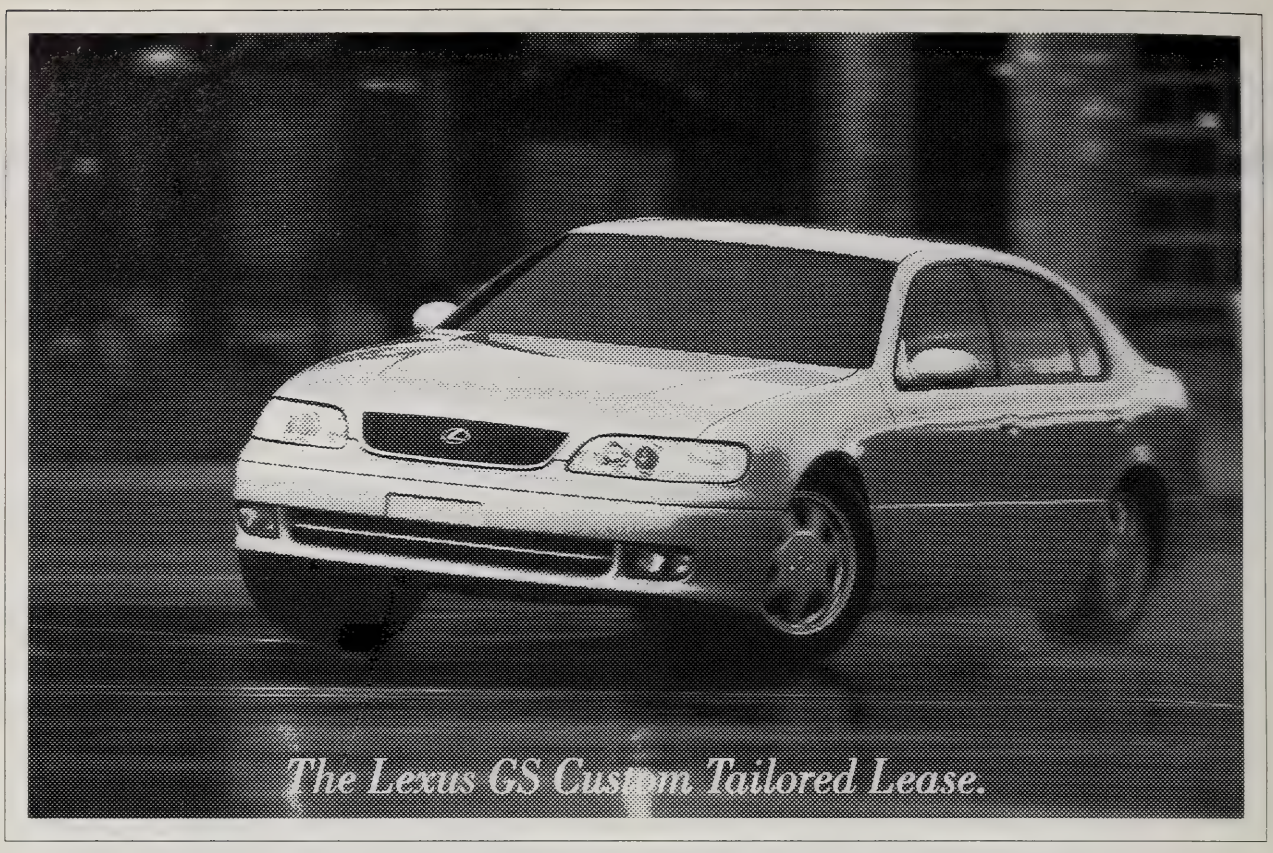
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About the Cover

Robert Shaw, MD, who practices neonatal-perinatal medicine at Iowa Methodist Medical Center in Des Moines, observes a tiny, sleepy patient. (Photo by Robert Willits.)

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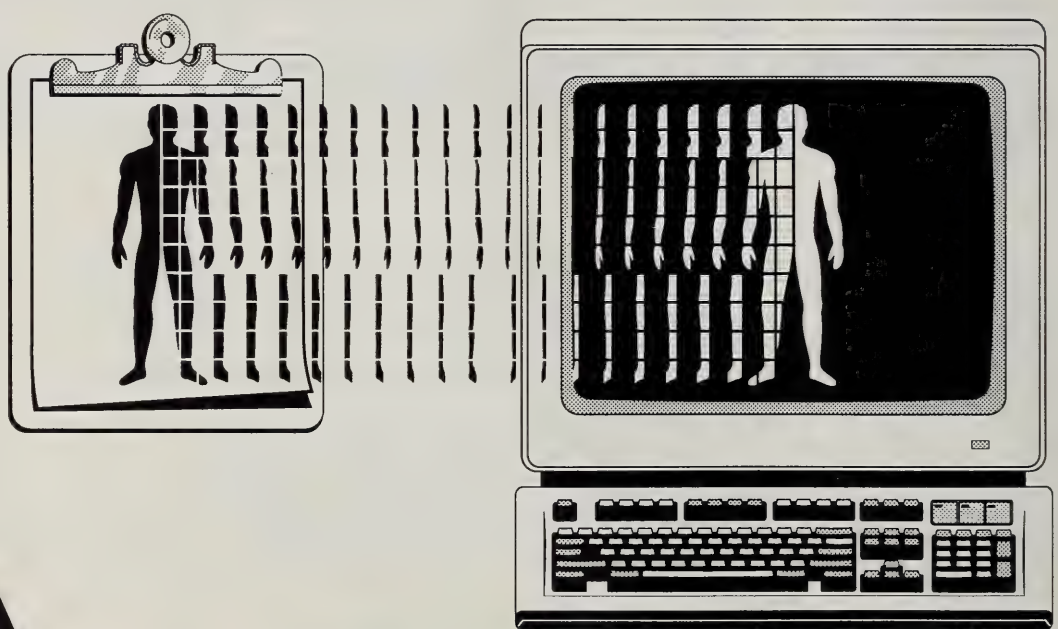
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No matter who gets final control of Iowa's fiber optic network, there are many possible applications in medical practice. Four Iowa physicians speculate about the future of telemedicine. ● *CHRISTINE CLARK*



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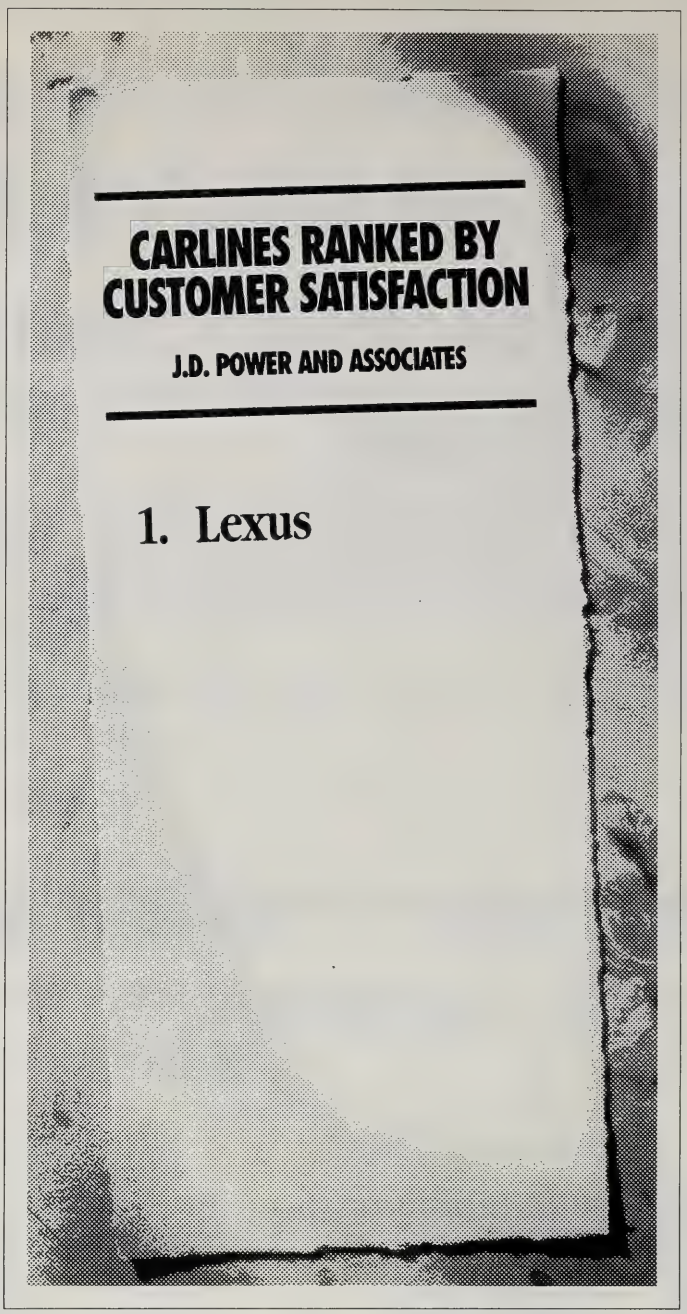
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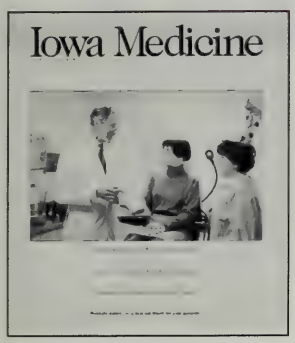
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About the Cover

James White, MD, a Dubuque otolaryngologist and new IMS president, with patient Lynn McCullough and nurse Deb McGinnis. (Photo by Karen Knepper, Finley Hospital, Dubuque.)

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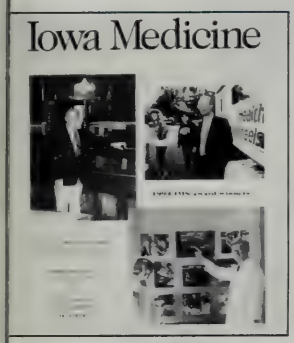
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About the Cover

On the cover are 1994 IMS award winners. Clockwise, from left — Dr. Jackson Ver Steeg, IMPAC chairman and winner of the 1994 Merit Award; Dr. Peter Wallace, Iowa City pediatrician and winner of the Physician Community Service Award; and Dr. Paul Seebohm, retired UI associate dean and winner of the Distinguished Service Award.

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Broken noses and fractured jaws are signs of trauma, but they can also be signs of domestic violence.

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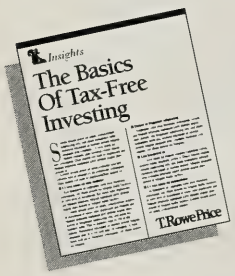
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FEATURE ARTICLE

300 **Hiring a key employee**

Your ability to attract and maintain a quality staff is a key factor in the success of your practice. These experts offer tips on recruiting, interviewing and hiring.
● *Thomas Hamilton and Derrick Luttrell*



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The second of a two-part series on the importation of Hansen's Disease into Iowa. ● *Richard Caplan, MD*

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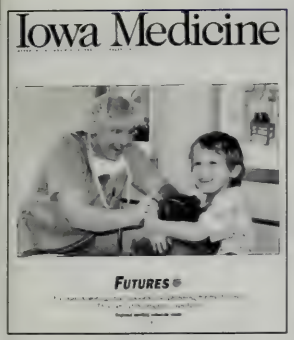
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About the Cover

Dean Lyons, MD, a Burlington otolaryngologist, makes a grab for a teddy bear held by a young patient, Peter Grossenkemper of Fort Madison. "Spinoza" the teddy bear talks and sings to children before they go into the operating room.

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Feedback on just a few of the weighty issues addressed at the recent AMA Annual Meeting in Chicago.

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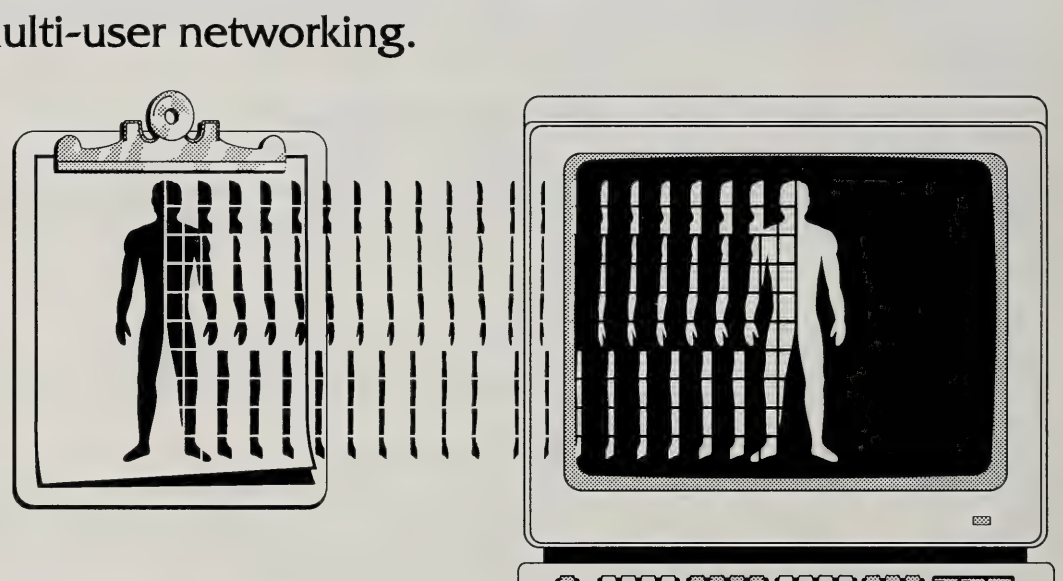
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FEATURE ARTICLE



344 **Responsibility and justice . . . an ethical balance**

What should be the criteria for allocation of scarce resources such as livers? This author makes a case that the public good should be the prime consideration in transplantation decisions.

● *CURTIS REYNOLDS, MD*

SCIENCE AND EDUCATION

349 **Transplantation of patients with alcoholic liver disease**

The authors cite recent data which suggest alcoholic patients with end-stage liver disease who meet stringent selection criteria may achieve a favorable outcome. ● *TERRI GERDES, MD; WILLIAM YATES, MD; MAUREEN MARTIN, MD; DOUGLAS LABRECQUE, MD*

354 **Extramedullary plasmacytoma of skin, bowel and bladder**

Description of a case which demonstrates the range extramedullary plasmacytomas can manifest in association with multiple myeloma.

● *DEAN GESME, JR, MD; DENNIS BOATMAN, MD; GARY WEINMAN, MD; HAMED TEWFIK, MD*

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Housing tax credits too good to be true?

Financial services industry often overlooks housing tax credits as one of the best techniques for reducing your federal tax liability.

One of the most effective and frequently overlooked methods of reducing federal tax liability is the Low Income Housing Tax Credit. The federal government recognizes that a tremendous gap exists between the supply and demand for affordable housing in the United States. Fortunately in response to this need, Congress has elected to present investors with a tremendous opportunity. As an incentive to develop low income housing, they authorized the use of a federal tax credit in 1986. Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

150 Percent Credit

Investors in low income housing are projected to receive tax credits equal to approximately 150% of their investment, although sometimes it can range as high as 190% of their investment. The total amount of credits is distributed equally over 10 years. For example, a $10,000 investment would yield tax savings of approximately $1500 per year for the next 10 years, for a total of $15,000. As previously stated, the total may be as high as $19,000 for every $10,000 invested. Depending on factors such as an investor's income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using Low Income Housing Tax Credits.

In addition to the credit, there are other potential benefits which can be realized. Cash flow from operations can result if the properties are profitable. This comes in the form of distribution checks sent directly to investors. Generally, all cash flow distributions are completely sheltered from taxes.

As an equity investor, you also own part of an apartment complex, in addition to the credits and cash flow. When the properties are sold, they may be sold at a profit. Again, a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Social Benefits

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The funds raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. These programs are *not* government projects, tenants must meet certain income criteria, *but their rents are not subsidized.* As in any other apartment complex, the tenants are subjected to references and employment checks to make sure they are desirable renters.

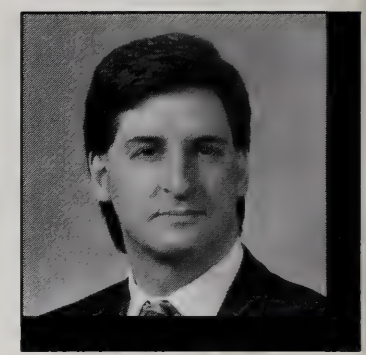
Perhaps the greatest obstacle tax credits face is that they sound too good to be true. That is, until you mention that the only form they are available in is that of a limited partnership. Any time real estate and limited partnerships are mentioned in the same breath, people are conditioned to run for their financial lives! However, these programs differ significantly from the real estate programs commonly known as "tax shelters" that were promoted in the early 1980s.

Figuratively speaking, old tax shelters granted the general partner a license to steal. The fees in the programs were exorbitant and the amount of borrowed money involved excessive. If that wasn't enough, Congress put a stake through their heart in 1986 by eliminating or postponing the tax benefits these programs were designed to deliver.

Partnerships are under much more scrutiny from investors now. Tax benefits are rarely the sole motivating force behind these investments. It should be pointed out however, that should an investor in Low Income Housing Tax Credits receive only the credit and no other benefit, they have done well. The tax credits, if fully earned, are projected to produce a respectable 6 to 14% after tax return on their money.

The other benefits such as cash flow and appreciation and use of the passive losses could enhance the return even more.

As is true of all real estate investments, housing tax credits are not without risk. Tax credits are complicated and not everyone can use them. However, in taking a survey of current and past performance of these properties indicates the results have been very favorable. Demand for affordable housing is enormous and in most markets these properties operate with occupancies in the 95-100% range. This is significantly higher than the breakeven occupancies typically around 65-75%.



Financial planner Don DeWaay says housing credits can be a gold mine for investors.

Do Your Homework

It is important to evaluate each program on its own merits. Always scrutinize the track record of the General Partner. There are always spread sheets or "pro formas" that outline the expected benefits from these investments. Compare these against actual performance on prior programs. Read the prospectus carefully, noting fees and structure of the program. It is to the investor's benefit to keep the fees below 20%. This may sound high, but when you examine what it costs to register and develop a program it is quite reasonable. Also look for programs that use lower leverage or in other terms, lower amounts of borrowed money. Commonly, projects in LIHTC use moderate to low leverage in the 50-80% range. The lower the leverage, the more likely the property is to cash flow.

Prior to investing, you should always know all the particulars about a project. Pay close attention to the real estate markets where the properties are located. Look for a solid employment base and economic growth potential. Also look for areas with high median income which allows the properties to increase rents. A good rental market will enhance the outlook for cash flow and appreciation in the properties value. In short, do your homework. Most of these programs appear to be working well, but they are not uniform at sale. Some definitely offer more potential than others.

If all this sounds too confusing or complicated, the alternative is much easier. Simply continue to write your checks to Washington every April 15th. For that, you get no liquidity, no return and your holding period is forever. When tax credit programs perform as designed, you redirect dollars that would have been used to pay taxes and put them back in your pocket to add to your net worth. With that in mind, it's easy to see why these programs are so widely used by corporations and individuals.

Don DeWaay
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1102 Grand Avenue
West Des Moines, IA 50265
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Iowa Medicine

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About the Cover

Dr. Sharon Collins, a Cedar Rapids pediatrician, is pictured with a happy patient. The American Medical Association has designated September as "Women in Medicine Month". *The photo was taken by Sandy Sloan of St. Luke's Hospital.*

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375 **Strategies for the future**

A new IMS program will help you explore your options and plan for the future of your practice in a new environment.

● *THE PRESIDENT COMMENTS*

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IMS *DEADLINE* news

SEPTEMBER, 1994

Late-breaking news of interest to Iowa physicians

•**THERE IS LITTLE CHANCE** health system reform will pass this year, according to a story in the August 25 *Los Angeles Times*. The *Times* said the White House hopes to contain the damage to the presidency by laying groundwork for health system reform to be revived in January of 1995. However, some AMA staffers believe an incremental approach to reform could still go through this year. As of press time, AMA continued to push its support for the bipartisan bill sponsored by Rep. Roy Rowland.

•**IN A RECENT MEETING WITH MEMBERS** of the IMS Board of Trustees and AMA delegation, Dr. Robert McAfee, AMA president, said the AMA's top priorities in health system reform will continue to be no further Medicare cuts, tort reform with a cap, antitrust reform and inclusion of provisions from the Patient Protection Act in any health system reform bill. AMA representatives have conducted over 300 one-on-one visits with members of Congress during recent weeks.

•**A COURT HEARING** on the Medicaid Managed Mental Health Care contract has been postponed until September 26. Iowa Dept. of Human Services awarded the $102 million contract to Value Behavioral Health of Virginia, a decision which is being challenged by a losing bidder.

•**MEANWHILE, MEDIA ANALYST** Kathleen Hall-Jamieson of the University of Pennsylvania told a group of Midwest legislators the media has contributed greatly to the fact that people are "anxious and confused" regarding health system reform. She blames the media's proclivity for "he said, she said reporting" which covers charges and counter-charges rather than substantive issues, objective analysis and fact.

•**TELEMEDICINE'S USES IN** prehospital emergency medicine will be demonstrated from 11 am to 5 pm September 21 at the STARC Armory in Johnston. Anyone is welcome. For more information, call Becky Roorda of the IMS staff.

•**THERE WILL BE A DELAY IN** mailing of enrollment forms for the federal Vaccines For Children (VFC) program due to the last-minute cancellation of the national vaccine warehouse. Iowa now finds itself with no mechanism to ship vaccines to private physicians without sizeable financial increases in the program's funding. Watch the October ***Iowa Medicine*** for more details about the implications for Iowa's VFC program.

•**GOOD NEWS FOR CARDIAC CATHETERIZATON PAYMENTS.** HCFA has revised its computation and the payment for catheterizations. This is a big win for Iowa cardiologists. For more details, see the Practice Management section of the October ***Iowa Medicine.***

•**MEDICINE WON A VICTORY** recently in the House Judiciary Committee when members reversed an earlier decision and adopted an antitrust relief amendment on an 18-17 vote. The amendment exempts medical self-regulatory activities from antitrust laws if the conduct falls within one of seven defined safe harbors.

•**IF YOU DON'T KNOW WHAT** HEDIS is, you should. Watch the October ***Iowa Medicine*** for the first of three inserts explaining this employer measure of health care providers' performance.

For more information about any *DEADLINE* news item, call Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070.

FEATURE ARTICLES

389 **Futures . . . strategies for tomorrow's practice**

Don't miss this important series of articles which will help you prepare for the Iowa Medical Society's ***Futures*** program, which begins this month with a series of regional meetings around Iowa. The reprinted articles come from expert consultants who discuss key issues in planning a strategy that will ensure the success of your practice. The articles cover the following issues:

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397 **Expanded maternal serum alpha fetoprotein screening**

Screening for a variety of fetal conditions has reflected successful partnerships among various groups. ● *ROGER WILLIAMSON, MD*

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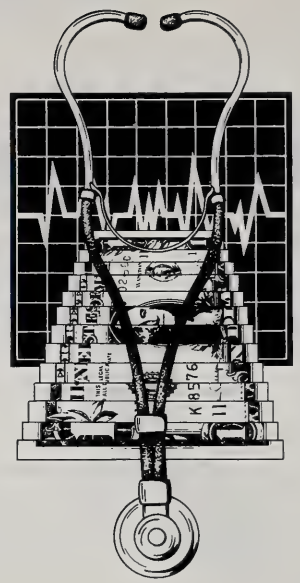
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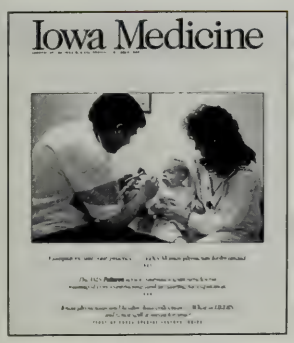
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About the Cover

A follow-up visit by Holly Hearn and her mother Ann to Dr. David Kemp, a Dubuque pediatrician, reveals that prompt treatment of her ear infection was successful. (Photo by Karen Knepper, Finley Hospital, Dubuque.)

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EDITORIAL

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The AMA's Patient Protection Act is designed to keep clinical decisions where they belong — in the hands of patients and their physicians.

● *THE PRESIDENT COMMENTS*

425 **Zero tolerance for violence**

The Iowa Medical Society Alliance discusses that organization's efforts to educate the public about the effects of violence.

● *BARBARA BELL, IMSA PRESIDENT*

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- *'Don't shoot the messenger'* says Des Moines physician

IMS DEADLINE news

OCTOBER, 1994

Late-breaking news of interest to Iowa physicians

•**THE AMA AND IMS SCORED A BIG VICTORY** September 14 on behalf of Iowa physicians when a Minnesota district court judge declared that state's 2% tax on gross revenues of health care providers unconstitutional for physicians in neighboring states. The AMA and IMS had challenged the constitutionality of the tax. An AMA attorney told the IMS Executive Council the tax on out-of-state providers was "idiocy" but that the state of Minnesota could appeal. Eldon Huston, IMS executive vice president, said the successful lawsuit is "an example of how the AMA and state medical societies can work together on behalf of physicians." Watch the November *Iowa Medicine* for more details on the IMS role in the suit.

•**IF YOU DON'T KNOW ABOUT THE** health data collection efforts that are underway, you should! Don't miss the insert in this month's magazine describing HEDIS (the Health Employer Data Information Set) and other key efforts by large employers.

•**THE REGIONAL FUTURES MEETING** for physicians in Atlantic and surrounding areas has been rescheduled for Thurs., Oct. 20. The meeting will be 7 to 9 p.m., Atlantic Country Club.

•**TELEVISION COMMERCIALS FEATURING** "Dr. Bob" (AMA president Robert McAfee, MD) aired during the past month on CNN and CNBC. The ad campaign focused on health system reform, with Dr. McAfee discussing the AMA's Patient Protection Act, increased tobacco taxes, insurance reform and professional liability reform as desirable reform measures.

•**IT'S NOT TOO LATE TO REGISTER** for the Iowa Medical Society's statewide FUTURES conference Thursday, October 27 at the Marriott Hotel in Des Moines. Four expert consultants will discuss the pros and cons of various practice models, new sources of funding for new organizations, physician contracts and who is aligned with whom in Iowa. Dr. James Todd, AMA executive vice president, will be the luncheon speaker. Call Barbara Heck at 800/747-3070 or 515/223-1401 for more information or to register.

•**IN NOVEMBER, IMS WILL OFFER** a series of seminars on E & M Coding which will include the new HCFA documentation guidelines. For more information, call Barbara Heck at IMS.

•**CREATION OF A STRONG PO** (Physician Organization) is essential for developing a successful PHO (Physician-Hospital Organization), according to a recent study cosponsored by the AMA and state societies in Indiana, Michigan and Illinois. A copy of the 105-page report, *Case Study Analysis of Physician Hospital Organizations*, can be ordered by calling the Michigan State Medical Society, 517/336-5776 ($20 for AMA members; $95 for nonmembers).

•**IMS AND BOARD OF NURSING REPRESENTATIVES** met recently to discuss proposed rules implementing legislation which will allow ARNPs to prescribe controlled and noncontrolled drugs. The IMS opposes the proposed rules because they would eliminate an existing requirement that ARNPs practice as part of an interdisciplinary team with physicians. The proposed rules also fail to address the issue of prescribing and were not developed in consultation with the Board of Medical Examiners as required by law. No agreement was reached.

•**AS THIS ISSUE OF *IOWA MEDICINE*** went to press, Senator George Mitchell had declared health system reform "dead" for the year. President Clinton vowed to continue fighting for universal coverage next year.

For more information about any *DEADLINE* news item, call Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070.

Feature Articles

440 **Managed care contracting: a road map around potholes**

Physicians shouldn't enter into any contract without serious consideration of professional and personal goals. The author, a Chicago attorney who is familiar with Iowa contracts, says any contract must be subjected to intense scrutiny. ● *Kenneth Davis, JD*

444 **Preparing for capitation**

The author, president of an Illinois consulting firm, answers the question on many physician's lips: How can I realign my practice to prepare for capitation payment? *First of two articles.* ● *William DeMarco*

FUTURES
Strategies for tomorrow's practice©

Mr. Davis and Mr. DeMarco — along with AMA Executive Vice President James Todd, MD — will be guest speakers at the Iowa Medical Society's *Futures* conference "Organizing for Change" October 27 in Des Moines. See page 439 for more details and registration information.

Science and Education

449 **Leptospirosis: a consequence of the Iowa flood**

The authors discuss two cases of leptospirosis in Iowa City residents exposed to flood waters during the summer of 1993. ● *Laurence Fuortes, MD and Mary Nettleman, MD*

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Iowa Medicine

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About the Cover

Peter Buck, MD, an orthopedic surgeon and sports medicine specialist with McFarland Clinic in Ames, examines a patient's shoulder for possible injury.

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EDITORIAL

471 **Health system reform is very much alive**

Health system reform is dead in Congress but if you fall asleep you could wake up to a changed world.

● *THE PRESIDENT COMMENTS*

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IMS *DEADLINE* news

NOVEMBER, 1994

Late-breaking news of interest to Iowa physicians

•**THE IMS HAS RECEIVED UNOFFICIAL** word that the Health Care Financing Administration will approve Iowa's application to be a single Medicare payment locality. Watch the November *Federal Register* and the December *Iowa Medicine* for official confirmation.

•**A SET OF CASSETTE TAPES** of the highly-successful IMS conference "Organizing for Change" is now available. The 4-tape set includes presentations by experts on capitation, Physician Organizations and other issues you will need to know about in the future. The tapes plus related materials are available for $42 (includes postage and handling). The tapes without related materials are available for $26.50. Call Linda Tideback or Barbara Heck at the IMS, 515/223-1401 or 800/747-3070 to order. Also, watch the December *Iowa Medicine* for a discussion of advice these experts offer to Iowa physicians.

•**THE AMA AND THE US CHAMBER OF COMMERCE** filed suit against the Federal Election Commission, saying its rules prevent them from communicating with their members about congressional candidates. The basis of the suit is that FEC rules violate the first amendment by imposing a political gag rule.

•**AMA IS CALLING ON CONGRESS** to use the Food and Drug Administration as a way to ensure that tobacco products are regulated, including the way they are manufactured, sold, labeled, advertised and promoted. For physicians who wish to collect names of people in favor of FDA regulation of tobacco products, IMS has a petition made available by the Coalition on Smoking OR Health. For a copy of the petition, call Chris Clark of the IMS, 515/223-1401 or 800/747-3070.

•**THE BOARD OF PHYSICIAN ASSISTANT EXAMINERS** has proposed new rules governing PAs. Among other changes, the proposed rules provide that a supervising physician must visit a remote clinic in person only once a month. (Current rules require the presence of the supervising physician every two weeks.) The public has until Nov. 17 to provide comments on the rules. For a copy of the rules, call Becky Roorda at IMS, 515/223-1401 or 800/747-3070.

•**THE WHITE HOUSE HAS RESHUFFLED** its health policy operations, putting Carol Rasco and Robert Rubin in charge of the reform effort and lowering the profile of Ira Magaziner. Rubin is assistant to the President on economic policy; Rasco is chief advisor on domestic policy. Political observers say many players inside and outside the White House believe Magaziner was a key reason health reform failed because too many groups were kept in the dark or ignored.

•**THE PROGNOSIS ON HEALTH REFORM,** according to the Medical Group Management Association's *Washington Report*, is that there will be no comprehensive reform before 1997 and that limited reform will likely be linked to welfare reform.

•**ARE YOU LOOKING FOR** an informative program for your county medical society or hospital staff medical meeting? As scheduling permits, the IMS has available a 30-minute slide presentation on the forces that will shape your future. The program is facilitated by Barbara Heck. Call IMS headquarters for more information on scheduling.

For more information about any *DEADLINE* news item, call Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070.

Feature Articles

488 **Finding the best consultant**

An increasing number of physicians are turning to consultants for assistance in designing and implementing successful practice development stategies. This article offers excellent advice on how to find and get the most from a consultant. ● *Thomas Gorey, JD*

492 **How capitation works**

The author, president of an Illinois consulting firm, discusses how capitation payment is working in places where managed care is a dominant market force. *Second of two articles.* ● *William DeMarco*

FUTURES
Strategies for tomorrow's practice©

Cassette tapes of presentations by Mr. Gorey, Mr. DeMarco and other experts at the Iowa Medical Society's *Futures* conference "Organizing for Change" are available for sale to IMS members. Please call Barbara Heck or Linda Tideback at 515/223-1401 or 800/747-3070 for details.

Science and Education

497 **Primary malignant melanoma of the upper lip**

Melanomas in this anatomically complex area present formidable obstacles to treatment.

● *Ahmed Ghouri, MD; Darren Killen, MD; Richard Firkins, MD; Kulachandra Devaiah, MD*

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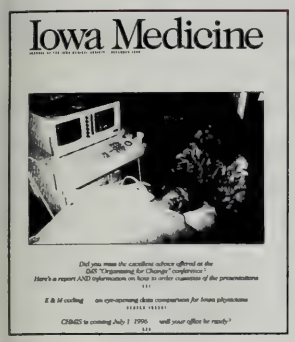
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About the Cover

André Langlois, MD, a Dubuque radiologist, uses the diasonics VST ultrasound machine to evaluate artery blockage in patient Kris Neenan. Photo by Karen Knepper, community relations coordinator for Finley Hospital in Dubuque.

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We have an opportunity to work toward closer cooperation between our physician specialty groups.

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IMS *DEADLINE* news

DECEMBER, 1994

Late-breaking news of interest to Iowa physicians

•**DON'T MISS THE CENTER INSERT** in this month's magazine, which gives plenty of interesting data on how Iowa physicians are using E & M codes as compared with physicians nationally in their specialties. Last month, the Iowa Medical Society completed a highly-successful series of programs on the subject of E & M Coding. If you missed the program in your area, you can attend one of a series of January programs. Call Mary Reinsmoen at the IMS, 515/223-1401 or 800/747-3070 for more information.

•**IN THE 1994 "DEAR DOCTOR" LETTER** mailed recently by Iowa's Medicare carrier, it was announced that HCFA has designated Iowa as a single Medicare payment locality with one statewide fee schedule. This will be effective January 1, 1995. The original request to be designated a single Medicare payment locality came from an Iowa Medical Society House of Delegates action in 1992 and was spearheaded by a significant number of practicing physicians. IMS has coordinated Iowa's petition to HCFA because equal Medicare payment throughout all areas of the state could help attract more physicians to rural Iowa.

•**MEDICARE BENEFICIARIES ARE BEING** urged to get flu shots. According to the Iowa Department of Inspections and Appeals, less than one-half of all Iowans who received Medicare benefits during 1993 took advantage of the federal medical insurance program's influenza immunization benefit. Medicare beneficiaries who get flu shots do not have to pay the usual coinsurance or deductibles if they receive the immunization from a physician who accepts Medicare assignment. Beneficiaries who get shots from physicians who do not accept assignment will be responsible for charges in excess of what Medicare pays. Medicare coverage of flu shots began May 1, 1993.

•**ENTITLEMENT SPENDING, INCLUDING MEDICARE** is likely to be a focus of the Republican-dominated Congress, say political pundits in the wake of the election. Even before the election, there were indications that the Administration plans to pursue Medicare cuts in 1995. According to the AMA, Chuck Booth, head of payment policy at HCFA, indicated in a recent speech that the "usual suspects" for budget-cutting next year would include "less than full updates for physicians and hospitals". According to Booth, surgical and primary care updates are currently in excess of Consumer Price Index levels. HCFA is also expected to scrutinize ambulatory care groups performing surgical and radiation services.

•**THE NEW CONGRESS WILL NOT DROP** health system reform, but will likely attempt smaller changes such as insurance reforms that would ban denial of coverage for pre-existing conditions, medical malpractice reform or tax relief for health care spending.

•**AT THE AMA'S SCIENTIFIC REPORTERS CONFERENCE,** Roy Schwartz, MD, AMA's group vice president of medical education, said by the year 2000 America will have 163,000 more physicians than it needs, perhaps even too many in primary care. However, the Council on Graduate Medical Education, a congressional committee, said there will be a surplus of 115,000 specialists and a shortage of 35,000 primary care physicians.

•**DON'T MISS THE JANUARY AND FEBRUARY ISSUES** of *Iowa Medicine*, which will be devoted to spouse battering. Experts who represent many disciplines will discuss various aspects of this complex problem. The special issues are part of a project initiated by the IMS Task Force on Domestic Violence to educate physicians who treat these patients.

For more information about any *DEADLINE* news item, call Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070.

FEATURE ARTICLE

532 **The future of medicine in Iowa**

At the Iowa Medical Society conference "Organizing for Change", experts had plenty of advice to offer Iowa physicians wondering what they should do to prepare for the future.

Center Insert

E & M Coding . . . An eye-opening data comparison for Iowa physicians

How do Iowa physicians stack up nationwide with physicians in their specialties? You might be surprised.

SCIENCE AND EDUCATION

535 **Optimal LT_4 dosage in primary hypothyroidism**

The role of pathogenetic causes in the optimal daily LT_4 dose in primary hypothyroidism. ● *Udaya Kabadi, MD*

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FUTURES
Strategies for tomorrow's practice©

Cassette tapes of presentations by Tom Gorey, Bill DeMarco, Ken Davis and other experts at the Iowa Medical Society's *Futures* conference "Organizing for Change" are available for sale to IMS members. Use the order form on page 534 or call Barbara Heck or Linda Tideback at 515/223-1401 or 800/747-3070.

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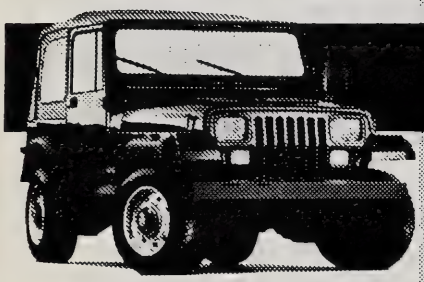
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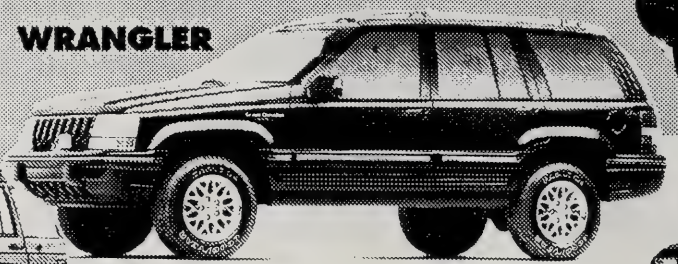
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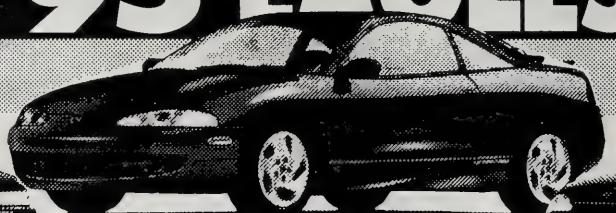


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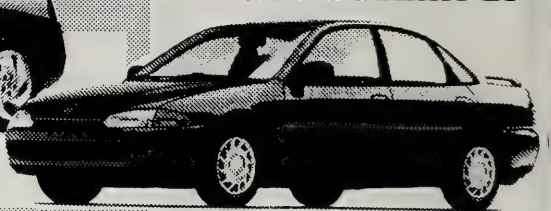
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The stakes are high n this brand new year

The holidays are over and we are starting a brand new year with a brand new look for *Iowa Medicine*. It has been redesigned to e more readable. In order to streamline our ublications, we have made the journal content nore comprehensive.

In addition to scientific and other articles which have always appeared in the Journal, we have now included material from our four newsletters. Chris Clark, IMS director of communications, and other IMS staff members have worked very hard and can be very proud of this new look. Let us know how you feel about the new format.

This promises to be a very important and pivotal year for medicine and for our patients. President Clinton's proposal is in the hopper and the congressional committees will be starting to dissect it this month. Also, the Iowa Legislature will be back in session this month and will begin work on Governor Branstad's health system reform proposals. Needless to say, health system reform will be our top priority this year. This will involve a tremendous amount of work and commitment. We must have everyone involved in this endeavor. The stakes are high and the outcome will affect every patient and physician.

No one can afford to be a spectator. It is not enough to contribute money to your favorite lawmaker or PAC. You need to forge a personal relationship with your legislators, help with their campaigns or host a fund-raiser.

It is not enough to contribute money to your lawmaker or PAC.

You must also become active in organized medicine as this will be our only seat at the bargaining table. Attend your county medical society meetings. Submit a resolution to the House of Delegates if you have a gripe or want to see something changed. In January and February, caucus meetings will be held across the state. Attend the one in your IMS Councilor District. The **IMS Update** section of this issue contains a schedule of dates and locations.

I know everyone is busy practicing medicine but we must make the time. We need everyone's perspective so we may speak with a unified voice in the health system reform debate. I also urge you to encourage your spouse to become involved with the IMS Alliance. The Alliance is one of our most valuable assets. They do much for our profession and our patients. Their health projects give us a tremendous public relations boost. They can also help contact lawmakers through their fantastic phone bank. Thanks, Alliance. Keep up the good work.

Lastly and most importantly, talk to your patients about the good and bad aspects of the various plans. We must educate them in order to gain their support.

If we all pitch in, work together and stay unified, I am sure we will have a happy and successful New Year. IM



JOHN ANDERSON, MD

IMS Update

AT A GLANCE

An Open Forum on Health System Reform will be held Saturday, April 16 in conjunction with the 1994 IMS Annual Meeting. Check the ***Health System Reform*** *section for more details.*

The 1994 IMS Scientific Session will be Friday, April 15 in conjunction with the House of Delegates. Watch the March Iowa Medicine *for a program and registration information.*

The IMS Board of Trustees will hold a dinner meeting Wednesday, January 12 with Iowa newspaper editors. Current health care issues will be discussed.

Want names of consultants or attorneys able to assist physicians in dealing with managed care issues? Call the AMA's Doctor's Advisory Network at 800/262-1066. (AMA members only.)

Nominees wanted for physician award

IMS is seeking nominees from member physicians across Iowa for its Physician Award for Community Service. This newly-created award will be presented during the 1994 House of Delegates.

The award will honor an Iowa physician who has provided outstanding civic, charitable and health services to patients and the community. Current or lifetime service will be considered; service should be uncompensated.

Anyone can nominate a physician by writing to Tina Preftakes at the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. The letter should provide the physician's name and address, a picture of the physician and a description of the nominee's service and why he or she should receive the award.

The deadline is April 1, 1994. Nominations will also be sought through local media. The recipient will be chosen by the IMS Board of Trustees.

Questions about medical records?

The new **Physician's Guide to Medical Records** is enclosed with this issue of *Iowa Medicine*. The guide covers legal and ethical implications of releasing and retaining medical records and answers many often-asked questions about these issues.

In December, IMS member physicians received the updated **Physician's Guide to Iowa Law**. Both of these documents are benefits of membership in the IMS and are a part of the Society's ongoing effort to help physicians cope with the changing health care environment.

Extra copies of either guide are available for a fee by calling Sheryal Westbrook at the IMS.

IMS, ISBA joint conference

The IMS Medical Legal Committee is meeting with representatives of the Iowa State Bar Association to develop plans for a February or March series of regional educational conferences on issues of mutual concern. Watch your mail for program and registration details.

Committee on IPA

Eleven physicians have agreed to serve on an IMS ad hoc committee which will study the feasibility of creating a statewide Independent Practice Association (IPA). The physicians represent various specialties and large counties which currently have an IPA.

The committee will begin meeting this month and will submit a report to the 1994 House of Delegates. This committee will also consider the question of "willing provider", a key issue in the study of IPA feasibility.

Seeking AMA office

Donald Young, MD, a Solon radiologist and IMS delegate to the American Medical Association, has announced his candidacy for election to the AMA Council on Scientific Affairs. His candidacy is endorsed by the IMS, the American Academy of Radiology and the North Central Medical Conference.

Dr. Young will seek election during the AMA Annual Meeting in June of 1994.

Specialty Society Update

About 25 cardiologists and cardiology office managers attended a recent workshop on Cardiology Reimbursement Strategies sponsored by Marion Merrill Dow and the Iowa Chapter of the American College of Cardiology.

Richard Preston, MD, a longtime Des Moines psychiatrist, is the recipient of the Iowa Psychiatric Society's Paul E. Huston Award. He received the award in honor of his exemplary service to the Iowa Psychiatric Society.

The Iowa Medical Group Management Association's Spring Meeting will be May 4-6, 1994 at the Des Moines Marriott Hotel.

ou're needed at IMS Annual Meeting

Participation by physicians across Iowa is eeded at the 1994 IMS Scientific Session and louse of Delegates Friday-Sunday, April 15-17 t the Savery Hotel, Des Moines. You are urged o make room reservations early by calling 15/244-2151. Reserve your room from the MS block.

Any IMS member can submit a resolution for onsideration by the 1994 House. Resolutions nust be sponsored by your county society, a lelegate or Councilor District and may address ny issue concerning medical care or practice.

The House of Delegates meets Saturday at :30 a.m. and Sunday at 10:00 a.m. County ocieties should be identifying their delegates o the 1994 House. Each county is entitled to at east one delegate and one alternate, with one ıdditional delegate and alternate per 15 active, esident or life members.

1994 IMS offices to be filled by the House nclude (length of terms in parenthesis): presi-lent-elect (1); vice-president (1); trustee (3); House of Delegates speaker (1); House of Del-gates vice-speaker (1); three AMA delegates (2); and one AMA alternate delegate (2).

Beginning in 1994, Judicial Councilors will be elected by a district wide vote of all eligible IMS voting members. Names of physicians elected as councilors will be submitted for confirmation by the House on April 17. Councilors in Districts 3,7,8,12 and 15 are up for election (all 3-year terms).

Each IMS Councilor District will hold a caucus to select officer candidates and discuss issues to be considered by the House of Delegates in April. At each caucus, physicians will choose a representative and alternate representative to the 1994 Nominating Committee. This committee will hold a telephone conference on Sunday, March 6 to compile a slate of candidates.

Below is the 1994 District Caucus schedule. If no information was available from your district at press time, contact your county society or Barb Walker at the IMS for site information, 515/223-1401 or 800/747-3070. IM

Focus on IMS Alliance

The Iowa Medical Society Alliance and the American Medical Association are helping with a project by the Citizens' Coalition Against Television and Movie Violence. IMSA is asking its members in Iowa to help circulate petitions asking the t.v. and movie industries to reduce violence and thereby reduce our children's exposure to violent programming.

Focus on IMS Alliance will be a regular feature in *Iowa Medicine*. Watch this column for news about Alliance projects and activities.

Contributed by Judy Hoenk, IMSA president

Beginning in 1994, Judicial Councilors will be chosen through a district-wide vote of all eligible IMS voting members.

Iowa Medical Society 1994 District Caucuses

District	Date	Location and Time	Councilor
1	1/19	Pzazz in Burlington at 6:30 pm	Robert Kent, MD
2	2/2	Highlander, Iowa City, after 6 pm meeting	Siroos Shirazi, MD
3	2/17	River City Cafe in Davenport at 7 pm	Eugene Kerns, MD
4	1/11	Mercy Cafeteria, Cedar Rapids, after 7 pm meeting	Albert Coates, MD
5	1/25	Knight-Light Supper Club in Dyersville, 6:30 pm	Ross Madden, MD
6	1/11	Prime & Wine in Mason City at 6:30 pm	John Justin, MD
7	*Contact the IMS for date and site*		Steven Erickson, MD
8	1/12	Steak Center in State Center at 6 pm	Leo Milleman, MD
9	1/4	Ottumwa Country Club in Ottumwa at 6 pm	Don Orelup, MD
10 & 11	2/16	Metropolitan Club in Des Moines at 6 pm	Don Green, MD C. David Smith, MD
12	1/18	Club 64 in Council Bluffs at 6:30 pm	John Fernandez, MD
13	*Contact the IMS for date and site*		Linda Iler, MD
14	1/25	Chateau Restaurant in Pocahontas at 7 pm	Stephen Richards, DO
15	1/20	Sioux City Country Club after 7 pm dinner	Kathryn Opheim, MD

Health System Reform

AT A GLANCE

Iowa Governor Terry Branstad participated in an AMA regional health system reform conference held in Dallas on November 5.

Over 23,000 physicians responded to an AMA mailing, asking to become involved in the health reform debate.

A recent ***Kiplinger Newsletter*** *predicted odds are against passage of a comprehensive health system reform plan in 1994. "Too complex and controversial" for an election year, said Kiplinger.*

Many Washington insiders believe the biggest challenge to the Clinton plan will be a growing coalition of "centrists" advocating reform without employer mandates and cost controls.

Open forum on health system reform

All Iowa physicians are urged to participate in a special Open Forum on Health System Reform to be held Saturday morning, April 16 in conjunction with the IMS House of Delegates meeting at the Savery Hotel, Des Moines.

The forum will begin at 10:30 a.m. following an abbreviated House of Delegates session. It will feature a panel discussion by representatives of the following specialty societies who are major players in the debate and represent the vast majority of Iowa physicians: Iowa Academy of Family Physicians; American Society of Internal Medicine, Iowa Chapter; American College of Surgeons, Iowa Chapter; American Academy of Pediatrics, Iowa Chapter.

Dr. William Eversmann, an IMS representative on the Governor's Health Reform Council, will also participate and Dr. Nancy Dickey will represent the AMA on the panel.

An open question and answer session will also be a key component of the forum. The session will be followed by a luncheon and Reference Committee hearings.

CHMIS legislation is being drafted

A broad-based CHMIS Steering Committee chaired by Walt Tomenga of the Iowa Farm Bureau is drafting legislation to implement recommendations on a Community Health Management Information System (CHMIS) for Iowa. CHMIS, generally accepted among policymakers as the information component of health system reform at the state level, will be considered by the 1994 Iowa Legislature.

The IMS supports the concept of an electronic claims system and standard claims forms as a means toward more cost-effective and efficient health care delivery. However, IMS is opposed to placing medical records or other confidential patient information in any electronic system. An IMS committee is monitoring this issue and the forthcoming legislative proposals.

Due primarily to concerns about patient confidentiality expressed by IMS representatives on the CHMIS Steering Committee, preliminary recommendations of the committee provide that information will be collected from claim forms, similar to data now maintained by third party payers. Further legislative authority would have to be granted later in order to collect patient medical record information.

CHMIS will be the subject of a feature article in the February *Iowa Medicine*. The article will discuss what CHMIS might mean for Iowa physicians and their patients.

Q & A session with Magaziner

In a meeting with representatives of specialty and state societies held in Washington, DC, Ira Magaziner said President Clinton wants to be flexible and open to making modifications in his health system reform plan.

The two-hour session with Magaziner, who is the senior White House policy advisor, consisted mostly of questions and answers.

Magaziner said health security and universal coverage are the only non-negotiable items in the Clinton proposal and predicted there will be a six to nine-month debate before any reform plan is passed by Congress.

Magaziner noted the differences in salaries between primary care physicians and other specialties and reiterated the president's goal of creating a better balance and a focus on prevention.

With regard to liability reform, Magaziner said there is no provision for a cap on noneceonomic damages because the administration does not want to "penalize consumers who are victims." The Clintons do support alternate dispute resolution, collateral source rules and periodic payments. (All of these reform measures already exist in Iowa.)

Meanwhile in Congress, the financing mechanism in the Clinton plan is coming under increasing scrutiny. Many lawmakers remain skeptical about exactly how the White House plans to fund its reform effort.

overnor's task force finalizing work

The Iowa Health Reform Council held two xtended meetings in late November and De- ember in order to finalize recommendations om 16 subcommittees. The group's final re- ort will go to the Governor and the 1994 Iowa egislature.

The final reform plan was not available at ress time. However, IMS staff involved in the roject had received an indication of what will robably be recommended.

Several of the subcommittee reports called or tort reform, antitrust reform and ERISA xemptions as part of reform at the state level. Iowever, the subcommittee which was as- igned these issues — a group which consisted rimarily of attorneys — did not recommend neaningful reforms in these areas. Physician nembers of the Council planned to continue ushing for these necessary reforms.

In addition, the Council planned to recom- mend that workers' compensation not be part f Iowa's health/accident insurance system.

Key decisions which emanated from the Council's last meetings include:

Rural access — A comprehensive package of economic incentives to attract primary care providers to rural areas will be recommended.

Medicare — The Council wants to correct the program's anti-rural bias.

Benefit design — The Council proposes an implementation plan to define a set of health benefits available to all Iowans.

Insurance reform — Recommendations include community rating and varying rates according to health choices made by patients.

Community-based purchasing — The Council endorses creation of voluntary purchasing cooperatives to organize small buyers to negotiate price and quality.

Cost control — A statewide health accounting system to better track where money is spent. An expenditure target would be established, but not as a strict budget. IM

Worth Repeating

At a recent IMS meeting on health system reform, an Iowa physician warned that federal reformers could use a ' divide and conquer' strategy among various physician specialties.

"It's not a victory when you convince the cannibals to eat you last," he commented.

A medical update for primary care physicians.

You are invited to attend a special medical conference for primary care physicians on Friday, March 4, 1994, at Bergan Mercy Medical Center, 7500 Mercy Road, in Omaha.

You will be updated on the current concerns and care of:

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- **describing evaluation and diagnosis**
- **describing therapeutic options**
- **discussing patient follow-up**

Registration is $25 per physician and includes course materials, lunch and break. This conference is sure to fill up quickly, so we are taking registrations on a first-come basis. **For a brochure, more information, or to register, call (402) 398-6192.**

Bergan Mercy Medical Center is accredited by the Nebraska Medical Association Commission on Medical Education to sponsor continuing medical education for physicians. Bergan Mercy Medical Center certifies that this continuing medical education offering meets the criteria for 4.5 hours of credit in Category 1 of the Physicians Recognition Award of the American Medical Association, or any other organization that recognizes Category 1 credit, provided the program is used and completed as designed.

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Legislative Affairs

IMS legislative priorities finalized

The Iowa Legislature is sure to consider some type of health system reform during its 1994 session, which convenes January 10.

High on the Legislature's agenda — and on the IMS issues list — are recommendations of the Governor's Council on Health Reform (see story in **Health System Reform** section).

The Iowa Health Reform Council was scheduled to have recommendations ready by the start of the legislative session. The 60-member council and its subcommittees are working on various aspects of the reform effort.

Other state legislative priorities approved by IMS leadership include:

Coverage for serious mental illness — IMS opposes discriminatory benefit limitations, copayments or deductibles for treatment of psychiatric illness under existing health plans and opposes discrimination in any proposed plans for national health care coverage.

CHMIS — The Community Health Management Information System Steering Committee is developing recommendations for greater use of electronic media within the health system. The IMS supports electronic billing and claims payment but opposes development of a central repository for medical records.

Fiber optic communications — IMS believes allowing physicians and hospitals access to fiber optic technology will ultimately benefit patients. IMS supports a change in statute to allow access to the Iowa Communications Network by the health care community.

Liability reform — This continues to be a top IMS priority. Efforts to reform the health care delivery system and contain costs will not work without meaningful liability reform. IMS supports a $250,000 cap on noneconomic damages and a reduction in the statute of limitations for minors.

Health care tax — In 1992, Governor Branstad proposed a tax on health care to help balance the state budget. IMS led a coalition which successfully pointed out the negative effects of the tax on patients. IMS continues opposition to proposals for a health care tax or similar assessment on physician license fees.

Public health issues

Universal helmet law — The federal government requires states to enact comprehensive helmet use legislation for motorcyclists or face diversion of federal highway construction funds. IMS is working with the Helmet Law Coalition in support of helmet law legislation.

Tobacco free environment — IMS will work on proposals which will likely include prohibiting smoking in hallways, all worksites and licensed day care centers and requiring more separation of restaurant smoking areas.

Review HIV/AIDS laws — The IMS Committee on Legislation will review state laws governing HIV/AIDS to determine whether changes are needed.

Scope of practice issues

Many issues related to scope of practice of limited health practitioners are being discussed this year. Health system reform efforts have provided a new forum for these issues.

AT A GLANCE

IMS has begun a pilot project to assess the feasibility of practice parameters developed by specialty societies.

The effect of the 1993 floods on the state budget could be a key factor in the ability of the 1994 Iowa Legislature to address issues such as health system reform.

When you talk to a legislator about any health care proposal, always discuss its effect on patients, advises Kevin Cunningham, MD, head of the IMS Committee on Legislation.

The IMS supports a change in state statutes which would give the health care community access to statewide fiber optics communications technology.

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:

STATEHOUSE
Des Moines, Iowa 50309

You may also contact your legislator at home when the Legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, contact Lyn Durante of the IMS staff, 800/747-3070 or 515/223-1401.

Prescribing of controlled substances by nurse practitioners — IMS policy is that an advanced registered nurse practitioner (ARNP) may prescribe non-controlled substances and medical devices with concurrence of a physician. IMS does not support prescription by ARNPs of controlled substances.

Prescribing of "legend" drugs by pharmacists — IMS believes allowing pharmacists to prescribe drugs will not benefit patients because pharmacists are not trained in diagnosis.

Other issues

Self-referral restrictions — In 1993, legislation was discussed to restrict physician ownership and investment in certain health care facilities. This could be discussed again.

Limits on fees for copying patients' medical records — In 1993, legislation was discussed to limit the amount physicians and hospitals can charge for copies of medical records. IMS believes use of guidelines recently developed by the IMS and the Iowa State Bar Association is preferable to addressing the issue in state law.

Child support payment as a condition of licensure — Proposals have been made to help enforce child support payment agreements by making it a condition of maintaining a professional license. IMS is supportive of efforts to enforce child support agreements but believes licenses should be granted on the basis of issues relating to professional competence.

Contact lens prescription — The Iowa Optometric Association has asked the IMS and Iowa ophthalmologists to work with them on language to clarify the Code with regard to release of contact lens prescriptions to patients. The issue has arisen as a result of complaints to the Attorney General from consumers who would like to shop around for contact lenses but have been unable to obtain their prescriptions. Iowa law requires release of spectacle prescriptions but is unclear about contact lens prescriptions.

Appropriations

Board of Medical Examiners — IMS believes the BME should be fully funded through appropriations and that revenue collected from license fees should be appropriated to the Board.

Medicaid cost containment — Medicaid cost containment has been a major legislative issue for the past few years. Due to possible budget shortfalls, it is likely legislators will again look for ways to restrain the rate of increase in the Medicaid budget. Physician services account for 8.4% of the $912.7 million Medicaid budget for the 1993 fiscal year.

Statewide Family Practice Residency Program — IMS believes funding for this program is essential for ensuring availability of family physicians in rural and urban Iowa.

State Medical Examiner — IMS supports additional funding through the Department of Public Safety.

State Legislative Calendar

The legislature has created a series of "funnel" deadlines which are intended to shorten the session.

Monday, January 10	**First day of session**
Friday, March 4	**Last day for House bills to be reported out of House committees and Senate bills to be reported out of Senate committees**
Friday, March 25	**Last day for Senate bills to be reported out of House committees and House bills out of Senate committees**
Monday, April 4	**Only "exempt" bills and "unfinished business" eligible for consideration**
Tuesday, April 19	**Legislators' expense reimbursement ends Final adjournment in one or two weeks**

Bills exempt from deadlines include: Appropriations, Ways and Means, legalizing acts, leadership sponsored bills, conference committee reports, bills on the veto calendar, Administrative Rules Review committee bills and joint resolutions nullifying Administrative Rules.

IMS position papers available

Position papers on a number of key health care issues are available from the IMS public affairs staff. To get copies, call Lyn Durante at 515/223-1401 or 800/747-3070. Papers are available on liability reform, health system reform, CHMIS, fiber optics, tobacco issues, helmet law and others.

IMS Legislative Day

The Iowa Medical Society will sponsor a Legislative Day for physicians and Alliance members on Tuesday, March 15. The Legislative Day will be an opportunity to observe the Iowa Legislature in action. A briefing and a luncheon will be held at IMS headquarters prior to the trip to the capitol.

Health system reform has provided a new forum for scope of practice issues.

Legislative Affairs

continued

Key legislative committees

Most bills of interest to the IMS are assigned to a few key committees in each house.

Appropriations

Overall state budget, including Medicaid, Public Health and Board of Medical Examiners

HOUSE - 25 members
Corbett, Ron (R-Cedar Rapids) - Chair
Miller, Tom (R-Cherokee) - (Vice Chair)
Peterson, Michael (D-Carroll) - (Ranking Member)

Beaman, Jack (R-Osceola); Beatty, Linda (D-Indianola); Brammer, Phil (D-Cedar Rapids); Brand, William (D-Vinton);Branstad, Clifford (R-Thompson); Daggett, Horace (R-Creston); Dvorsky, Robert (D-Coralville); Gipp, Chuck (R-Decorah); Hahn, James (R-Muscatine); Hammond, Johnie (D-Ames); Hanson, Don (R-Waterloo); Hester, Joan (R-Honey Creek); Hurley, Charles (R-Fayette); Koenigs, Deo (D-Osage); McKinney, Wayne (D-Waukee);McNeal, Clark (R-Iowa Falls); Metcalf, Janet (R-Windsor Heights); Murphy, Pat (D-Dubuque); Running, Richard (D-Cedar Rapids); Weidman, Dick (R-Griswold); Wise, Phil (D-Keokuk); Vande Hoef, Richard (R-Harris)

SENATE - 25 members
Murphy, Larry (D-Oelwein) - (Chair)
Boswell, Leonard (D-Davis City) - (Vice Chair)
McLaren, Derryl (R-Farragut) - (Ranking Member)

Banks, Brad (R-Westfield); Bisignano, Tony (D-Des Moines); Borlaug, Allen (R-Waucoma); Buhr, Florence (D-Des Moines);Connolly, Michael (D-Dubuque);Fraise, Gene (D-Fort Madison); Gronstal, Michael (D-Council Bluffs); Horn, Wally (D-Cedar Rapid); Husak, Emil (D-Toledo);Judge, Patty (D-Albia); Kersten, James (R-Ft. Dodge); Kibbie, John (D-Emmetsburg); Kramer, Mary (R-West Des Moines); Lind, Jim (R-Waterloo); Palmer, William (D-Ankeny); Pate, Paul (R-Marion); Redfern, Donald (R-Waterloo); Rensink, Wilmer (R-Sioux Center); Rosenberg, Ralph (D-Ames); Tinsman, Maggie (R-Davenport); Varn, Richard (D-Solon); Vilsack, Tom (D-Mt. Pleasant)

Commerce

Health insurance regulation and mandated benefit issues, some liability issues

HOUSE - 23 members
Renken, Bob (R-Aplington) - (Chair)
Dinkla, Dwight (R-Guthrie Center) - (Vice Chair)
Hansen, Steve (D-Sioux City) - (Ranking Member)

Brand, William (D-Vinton); Cataldo, Michael (D-Des Moines); Churchill, Steven (R-Johnston); Corbett, Ron (R-Cedar Rapids); Doderer, Minette (D-Iowa City); Ertl, Joe (R-Dyersville); Gill, Patrick (D-Sioux City); Halvorson, Rod (D-Ft. Dodge); Halvorson, Roger (R-Monona); Hanson, Darrell (R-Manchester); Holveck, Jack (D-Des Moines); Larson, Chuck (R-Cedar Rapids); Lundby, Mary (R-Marion); McCoy, Matt (D-Des Moines); Metcalf, Janet (R-Windsor Heights); Millage, David (R-Bettendorf); Miller, Tom (R-Cherokee); Rafferty, Bob (R-Davenport); Renaud, Dennis (D-Altoona); Weigel, Keith (D-New Hampton)

SENATE - 15 members
Deluhery, Patrick (D-Davenport) - (Chair)
Palmer, William (D-Ankeny) - (Vice Chair)
Jensen, John (R-Plainfield) - (Ranking Member)

Bisignano, Tony (D-Des Moines); Fuhrman, Linn (R-Aurelia); Gettings, Don (D-Ottumwa); Gronstal, Michael (D-Council Bluffs); Kersten, James (R-Ft. Dodge); Lind, Jim (R-Waterloo); Pate, Paul (R-Marion); Priebe, Berl (D-Algona); Redfern, Donald (R-Waterloo); Sturgeon, Al (D-Sioux City); Varn, Richard (D-Solon); Welsh, Joe (D-Dubuque)

Health and Human Rights Appropriations Subcommittee

Iowa Dept. of Public Health, Board of Medical Examiners

HOUSE - 9 members
Hurley, Charles (R-Fayette) - (Chair)
Brunkhorst, Bob (R-Waverly) - (Vice Chair)
Murphy, Pat (D-Dubuque) - (Ranking Member)

Burke, Gordon (D-Marshalltown); Carpenter, Dorothy (R-W. Des Moines); Gries, Don (R-Charter Oak); Harper, Patricia (D-Waterloo); Martin, Mona (R-Davenport); Weigel, Keith (D-New Hampton)

SENATE - 5 members
Buhr, Florence (D-Des Moines) - (Chair)
Giannetto, Randal (D-Marshalltown) - (Vice Chair)
Tinsman, Maggie (R-Davenport) - (Ranking Member)

Bennett, Wayne (R-Ida Grove); Sturgeon, Al (D-Sioux City)

Communications and Information Policy

New committee in the Senate only, expected to deal with electronic health insurance claims processing issues

SENATE - 7 members
Varn, Richard (D-Solon) - (Chair);
Welsh, Joe (D-Dubuque) - (Vice Chair)
Fuhrman, Linn (R-Aurelia) - (Ranking Member)

Deluhery, Patrick (D-Davenport); Fraise, Gene (D-Ft. Madison); Jensen, John (R-Plainfield); Kersten, James (R-Ft. Dodge)

Human Services Appropriations Subcommittee

Medicaid

HOUSE - 9 members
Hester, Joan (R-Honey Creek) - (Chair)
Blodgett, Gary (R-Mason City) - (Vice Chair)
Hammond, Johnie (D-Ames) - (Ranking Member)

Dinkla, Dwight (R-Guthrie Center); Fallon, Ed (D-Des Moines); Haverland, Mark (D-Polk City); Houser, Hubert (R-Carson); Jochum, Pam (D-Dubuque); Plasier, Lee (R-Sioux Center)

LEGISLATIVE LEADERS

House of Representatives

Speaker
Harold Van Maanen
(R-Oskaloosa)

Majority Leader
Brent Siegrist
(R-Council Bluffs)

Minority Leader
Bob Arnould
(D-Davenport)

SENATE - 5 members
Varn, Richard (D-Solon) - (Chair)
Szymoniak, Elaine (D-Des Moines) - (Vice Chair)
Kramer, Mary (R-West Des Moines) - (Ranking Member)

Deluhery, Patrick (D-Davenport); Rittmer, Sheldon (R-De Witt)

Human Resources

Most public health issues, some scope of practice issues

HOUSE - 21 members
Plasier, Lee (R-Sioux Center) - (Chair)
Grundberg, Betty (R-Des Moines) - (Vice Chair)
Haverland, Mark (D-Polk City) - (Ranking Member)

Blodgett, Gary (R-Mason City); Boddicker, Dan (R-Tipton); Brammer, Phil (D-Cedar Rapids); Burke, Gordon (D-Marshalltown); Daggett, Horace (R-Creston); Grubbs, Steve (R-Davenport); Hammond, Johnie (D-Ames); Harper, Patricia (D-Waterloo); Hester, Joan (R-Honey Creek); Houser, Hubert (R-Carson); Hurley, Charles (R-Fayette); Martin, Mona (R-Davenport); McNeal, Clark (R-Iowa Falls); Meyer, James (R-Odebolt); Moreland, Michael (D-Ottumwa); Murphy, Pat (D-Dubuque); Ollie, Art (D-Clinton); Witt, Bill (D-Waterloo)

SENATE - 12 members
Szymoniak, Elaine (D-Des Moines) - (Chair)
Lloyd-Jones, Jean (D-Iowa City) - (Vice Chair)
Tinsman, Maggie (R-Davenport) - (Ranking Member)

Bartz, Merlin (R-Grafton); Bennett, Wayne (R-Ida Grove); Buhr, Florence (D-Des Moines); Judge, Patty (D-Albia); Kramer, Mary (R-West Des Moines); Riordan, James (D-Waukee); Rittmer, Sheldon (R-DeWitt); Sturgeon, Al (D-Sioux City); Varn, Richard (D-Solon)

Judiciary

Liability reform, right-to-die issues

HOUSE - 21 members
McNeal, Clark (R-Iowa Falls) - (Chair)
Hurley, Charles (R-Fayette) - (Vice Chair)
Brammer, Phil (D-Cedar Rapids) - (Ranking Member)

Boddicker, Dan (R-Tipton); Beatty, Linda (D-Indianola); Brand, William (D-Vinton); Dinkla, Dwight (R-Guthrie Center); Doderer, Minette (D-Iowa City); Grubbs, Steve (R-Davenport); Grundberg, Betty (R-Des Moines); Hansen, Steve (D-Sioux City); Kreiman, Keith (D-Bloomfield); Larson, Charles (R-Cedar Rapids); Martin, Mona (R-Davenport); McKinney, Wayne (D-Waukee); Millage, David (R-Bettendorf); Neuhauser, Mary (D-Iowa City); Peterson, Michael (D-Carroll); Rafferty, Bob (R-Davenport); Spenner, Gregory (R-Mt. Pleasant); Weidman, Dick (R-Griswold)

SENATE - 15 members
Sturgeon, Al (D-Sioux City) - (Chair)
Rosenberg, Ralph (D-Ames) - (Vice Chair)
McKean, Andy (R-Anamosa) - (Ranking Member)

Bisignano, Tony (D-Des Moines); Connolly, Michael (D-Dubuque); Drake, Richard (R-Muscatine); Fuhrman, Linn (R-Aurelia); Giannetto, Randal (D-Marshalltown); Lloyd-Jones, Jean (D-Iowa City); Pate, Paul (R-Marion); Redfern, Donald (R-Waterloo); Szymoniak, Elaine (D-Des Moines); Taylor, Ray (R-Steamboat Rock); Vilsack, Tom (D-Mt. Pleasant); Welsh, Joe (D-Dubuque)

State Government

Most licensure and scope of practice issues

HOUSE - 21 members
Carpenter, Dorothy (R-W. Des Moines) - (Chair)
Martin, Mona (R-Davenport) - (Vice Chair)
Beatty, Linda (D-Indianola) - (Ranking Member)

Cataldo, Michael (D-Des Moines); Churchill, Steven (R-Johnston); Drake, Jack (R-Lewis); Ertl, Joe (R-Dyersville); Fallon, Ed (D-Des Moines); Gipp, Chuck (R-Decorah); Halvorson, Rod (D-Ft. Dodge); Hanson, Darrell (R-Manchester); Hester, Joan (R-Honey Creek); Jochum, Pam (D-Dubuque); Larkin, Rick (D-Ft. Madison); Lundby, Mary (R-Marion); Peterson, Michael (D-Carroll); Renaud, Dennis (D-Altoona); Renken, Bob (R-Aplington); Running, Richard (D-Cedar Rapids); Spenner, Gregory (R-Mt. Pleasant); Tyrrell, Phil (R-North English)

SENATE - 17 members
Gronstal, Michael (D-Council Bluffs) - (Chair)
Kibbie, John (D-Emmetsburg) - (Vice Chair)
Rittmer, Sheldon (R-De Witt) - (Ranking Member)

Bisignano, Tony (D-Des Moines); Buhr, Florence (D-Des Moines); Dieleman, William (D-Sully); Drake, Richard (R-Muscatine); Fink, Bill (D-Carlisle); Giannetto, Randal (D-Marshalltown); Kramer, Mary (R-West Des Moines); Lind, Jim (R-Waterloo); McKean, Andy (R-Anamosa); McLaren, Derryl (R-Farragut); Pate, Paul (R-Marion); Priebe, Berl (D-Algona); Sorensen, Al (D-Boone); Welsh, Joe (D-Dubuque)

Transportation

Helmet laws and other traffic safety issues

HOUSE - 21 members
Spenner, Gregory (R-Mt. Pleasant) - (Chair)
Churchill, Steven (R-Johnston) - (Vice Chair)
Koenigs, Deo (D-Osage) - (Ranking Member)

Beaman, Jack (R-Osceola); Black, Dennis (D-Grinnell); Blodgett, Gary (R-Mason City); Brauns, Barry (R-Conesville); Cohoon, Dennis (D-Burlington); Corbett, Ron (R-Cedar Rapids); Eddie, Russell (R-Storm Lake); Fogarty, Dan (D-Cylinder); Halvorson, Rod (D-Ft. Dodge); Houser, Hubert (R-Carson); Jochum, Pam (D-Dubuque); Larkin, Rick (D-Ft. Madison); May, Dennis (D-Kensett); Ollie, Art (D-Clinton); Renken, Bob (R-Aplington); Royer, Bill (R-Essex); Weidman, Dick (R-Griswold); Welter, Jerry (R-Monticello)

SENATE - 10 members
Lloyd-Jones, Jean (D-Iowa City) - (Chair)
Fraise, Gene (D-Ft. Madison) - (Vice Chair)
Drake, Richard (R-Muscatine) - (Ranking Member)

Connolly, Michael (D-Dubuque); Dieleman, William (D-Sully); Fink, Bill (D-Carlisle); Gettings, Don (D-Ottumwa) Jensen, John (R-Plainfield); Kersten, James (R-Ft. Dodge); Pate, Paul (R-Marion)

Legislative Leaders

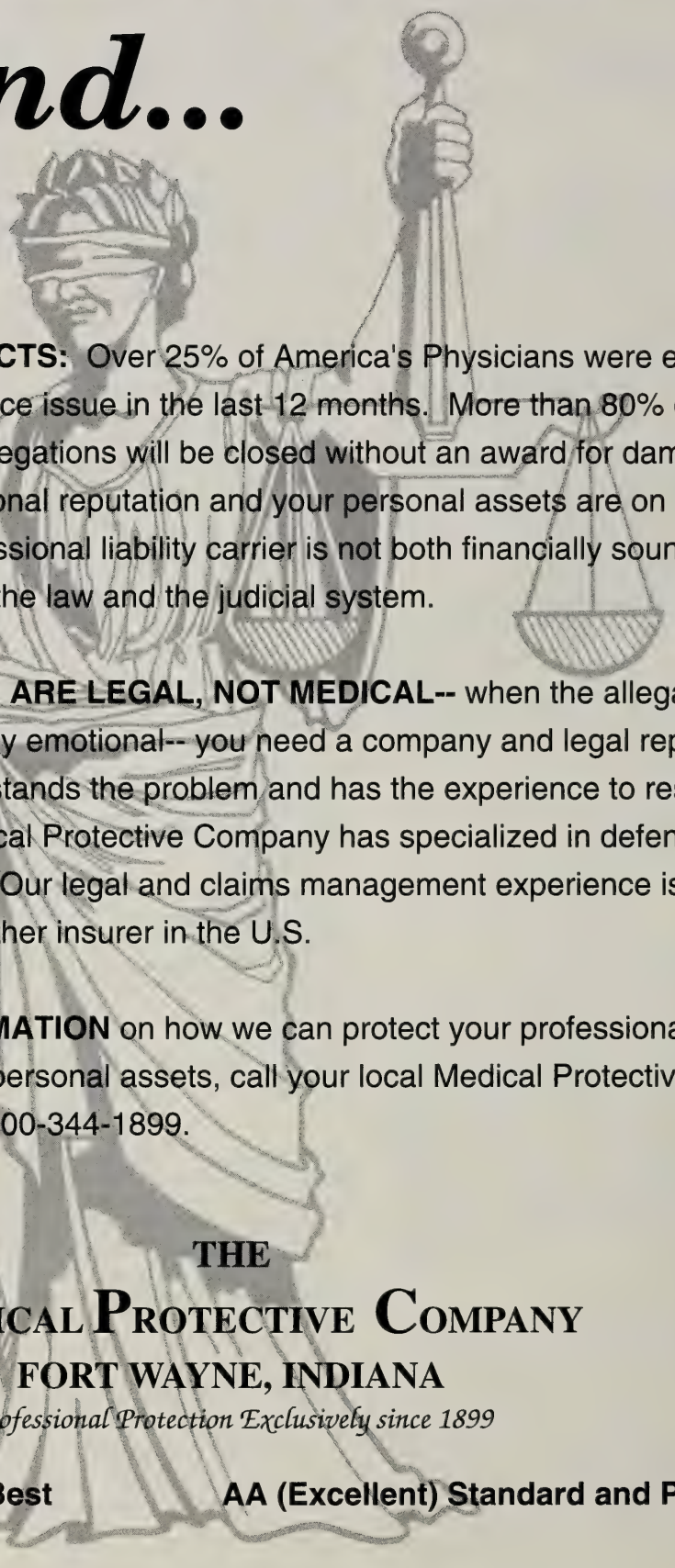
Senate

President
Leonard Boswell
(D-Davis City)

Majority Leader
Wally Horn
(D-Cedar Rapids)

Minority Leader
Jack Rife
(R-Durant)

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Medical Economics

IMS will appeal lawsuit decision

An IMS lawsuit on behalf of Iowa physicians who will be asked to pay a health care tax by the state of Minnesota has been dismissed. The trial court dismissed the suit on the grounds that a Minnesota statute prevents physicians from suing until the state actually attempts to collect the tax.

The tax is effective for services performed as of January 1, 1994. Minnesota intends to collect the tax from physicians in contiguous states who serve 20 or more Minnesota patients per year.

A lawsuit was filed by the AMA on behalf of physicians in Iowa and other contiguous states. The suit contends the tax is unconstitutional, an issue the trial court did not address.

The trial court's decision not to hear the case will be appealed. A lawsuit on behalf of Iowa hospitals subject to the tax is pending.

UI supports single Medicare locality

The University of Iowa College of Medicine Faculty Practice Plan now supports IMS efforts to have Iowa declared a single Medicare payment locality.

The 1993 House of Delegates directed the IMS to petition the Health Care Financing Administration (HCFA) to designate Iowa as a single Medicare payment locality. The request was made because physicians statewide will be paid the same for each service, thus increasing the possibility that physicians will be attracted to rural areas. The IMS also believes the move could support future attempts to eliminate national reimbursement inequities.

In 1992, HCFA denied a similar request because of opposition from the University of Iowa and the Polk County Medical Society. The UI and Polk County opposed the proposal because of reimbursement reductions which would occur under a single Medicare payment locality.

In early November of 1993, the UI notified IMS that its Practice Plan has agreed "without dissent" to support the IMS petition.

Members of the Polk County Medical Society are being surveyed in order to reassess support for the proposal. The request must be sent to HCFA by early February.

New IMS policy on Workers' Comp

The IMS Executive Council has adopted as policy a number of recommendations on reform of the Workers' Compensation system. The recommendations came from the IMS Ad Hoc Committee on Workers' Compensation.

In a comprehensive report, the committee outlined problems with the current system, including those that affect physicians. Committee members told the Executive Council that the following recommendations — if implemented together — will "enact positive change for all participants."

1. Establishment of a separate, uniform fee schedule that is negotiated by providers AND payers.
2. Periodic peer review and outcomes assessment to ensure quality of care.
3. New regulations concerning what is covered by Workers' Compensation.
4. Incentives provided by insurance companies for employers who promote a safe workplace and wellness.
5. Incentives provided by employers which promote wellness among employees.

Confusion over vaccine tax

There has been some confusion among Iowa physicians over details of a vaccine tax which was reinstated by the Omnibus Budget Reconciliation Act of 1993.

The tax is a one-day tax which applies only to vaccine in stock on August 10, 1993. From August 11 on, the tax was passed through the manufacturers.

This one-day tax must be paid by February 28, 1994 and reported on Form 720, Quarterly

AT A GLANCE

AMA members may find out their Unique Physician Identifying Number (UPIN) by calling 800/AMA-3211.

IFMC, Iowa's peer review organization, says it is moving away from analyzing individual medical records to a more equitable "practice pattern dialogue" with hospital medical staffs.

IMS staff is attempting to get details of the Governor's recent proposal to give income tax breaks to physicians who practice in rural shortage areas.

Blue Shield and the Iowa Psychiatric Society have agreed on "Outpatient Coding Guidelines", a safe harbor to avoid problems under Blue Shield audit.

Medical Economics

continued

Federal Excise Tax Return. The tax is used to fund a compensation program for victims of adverse reactions to immunizations.

Medicaid ER reimbursement change

The long-standing policy for use of the hospital emergency room has been to deny payment to the hospital if the Medicaid client was not referred by a physician and the visit was not an emergency as defined by the emergency diagnosis codes found in Chapter B, pages 16-45 of the Provider Manual. The entire visit charge is denied in this example and the hospital may bill the patient for the services.

If the patient was referred by a physician but the visit was not considered an emergency, the charges have been paid by Medicaid. If the service was considered an emergency but the patient was not referred by a physician, the charges were also paid.

A change in reimbursement to providers became effective July 1, 1993. The change is as follows:

The hospital emergency room payment will be reduced by one-half of the facility's rate if the visit is not considered an emergency (based on diagnosis codes) but the client was referred by a physician. This policy also applies to MediPASS physicians. Clients may not be billed for the difference between the ER charge and the amount paid by Medicaid.

Hospitals can submit claims to Unisys Medical Review if they feel the ER visit was an emergency and should be paid. Review requests can be sent to Unisys Medical Review, PO Box 10394, Des Moines, Iowa 50306.

Telephone inquiries can be directed to the Unisys Corporation at 515/226-2200.

IFMC members will be notified of election results in a mid-February mailing.

IFMC director elections underway

The election process to fill positions on the Iowa Foundation for Medical Care Board of Directors continues. Early this month, the IFMC will send ballots and a candidate slate to all voting members.

Four county representative director positions (MD), three area representative director positions (MD) and one area representative director position (DO) are up for election.

Separate ballots will be prepared for each county or district and will be mailed to members eligible to vote for the position in that county or district. Voting instructions will accompany the ballots; members must return their ballots in accordance with these instructions. Only official ballots will be honored.

IFMC members will be notified of the election results in a mid-February mailing. If you have questions about the election process, call William Vanderpool at the IFMC, 515/223-2170.

New utilization assessment studies

The IMS Utilization Assessment Committee, created to manage small area analysis study projects, has completed three studies and is beginning two new study groups. (Small area analysis is the study of treatment provided to patients according to their place of residence rather than the location of their treatment.)

Physician study groups were developed to interpret data on treatment of pneumonia and psychoses and knee arthroscopy in Iowa. These studies have been published and distributed to the respective specialty societies.

Two more study groups are being formed to develop information concerning treatment of pediatric asthma and tonsillectomy / adenoidectomy procedures in Iowa.

The study information is being mailed to other interested parties in an effort to provide data analysis from a clinical perspective.

For additional information or copies of the completed studies, contact Donna Bottorff, medical service manager, Iowa Medical Society, 515/223-1401 or 800/747-3070.

Catastrophic case management project

The IFMC has implemented a special study for the Health Care Financing Administration to provide case management services to selected Medicare beneficiaries. The IFMC moved into the active phase of the study on October 1, 1993 for a period of two years.

Medicare beneficiaries with a primary diagnosis of congestive heart failure or chronic obstructive pulmonary disease admitted to one of 10 selected facilities in Iowa and Nebraska are eligible to participate.

Once a patient is admitted with this diagnosis, the attending physician discusses the study with the patient and obtains the patient's written consent to participate. The patient has an equal chance of being selected for case management services at no charge for one year. The patient could also be selected for the control group. IM

Practice Management

MMIC rate reduction

Midwest Medical Insurance Company (MMIC) has announced a 1994 rate reduction of 8% to 13% for all policyholders. MMIC is the merged company which insures former IPMIT policyholders. Favorable loss experience and anticipated investment income are cited as the principal reasons for the rate reduction.

In 1994, Iowa physicians insured by MMIC will also see reduced classifications and rates for emergency medicine, anesthesiology, orthopedists not performing spine surgery and radiologists performing major invasive procedures.

Iowa physicians may obtain information on MMIC's competitive rates by calling Tom Leners at IMS Services, 515/223-2816 or 800/728-5398. Physicians involved in joining or forming practice groups are particularly urged to check MMIC since the company has much experience insuring large groups of physicians.

Don't miss the insert in this month's *Iowa Medicine* which has more information about what MMIC has to offer Iowa physicians.

Clinic manager nominations sought

Nominations are being sought for the 1994 Outstanding Iowa Medical Office Administrator Award. A panel of physicians and officers from the Iowa Medical Group Management Association will make the selection and the award will be presented at the IMS House of Delegates in April. To nominate a clinic manager, call Mark Templeton at IMS Services, 515/223-2816 or 800/728-5398. Deadline for nominations is February 28.

Medical business specialist program

For the first time, the IMS is offering a Medical Business Specialist (MBS) certification to physician office staff. The purpose of the MBS program is to provide certification for physician office staff which signifies their completion of a core curriculum in business operations of a medical office.

The MBS program has 10 core modules. Participants will pay an enrollment fee to begin certification and will have up to three years to complete the 10 modules. Modules will vary from three to eight hours in length.

The MBS program will begin early in 1994. Information will be mailed to all IMS and IMGMA members. For more information, call Barb Cannon or Sherry Johnson at IMS Services.

Employers face new reporting requirement

A new reporting requirement set forth in the Iowa Child Support Recovery Act is now in effect for all employers.

When an employee is hired, the employer must report certain information to a centralized employee registry which the state is in the process of establishing. Since the state has not

Upcoming Workshops for You and Your Practice

"Positioning Your Practice in a Competitive Environment"
(Cost — $60 for members; $75 for nonmembers)

Sioux City — Tuesday, January 18
St. Luke's Regional Medical Center

Des Moines — Tuesday, January 18
IMS headquarters
Wednesday, January 19
Westside Hospital

Cedar Rapids — Wednesday, January 19
Mercy Medical Center Cafeteria
Thursday, January 20
Kirkwood Community College

"Medical Terminology" — Wednesday, February 10
St. Luke's Hospital, Room 163, Cedar Rapids

For more information about any workshop or seminar listed here, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

AT A GLANCE

IMS Services staff are available for individual speaking engagements on 1994 CPT Coding changes. Call Barb Cannon at IMS Services, 800/728-5398.

In monthly staff meetings in one Iowa clinic, time is set aside to educate employees about a particular medical subject such as a common procedure or a disease frequently treated in the clinic.

Due to low claims experience, IMS has received a $20,596 dividend from 100 practices insured under the Workers Compensation Safety Group. The coverage is underwritten by the Farm Bureau Mutual Insurance Company. The dividend will be used to support ongoing office education activities which promote safety in the medical practice. Watch the February Iowa Medicine *for information on programs.*

Practice Management

continued

prepared a form, submission of an employee's Iowa W-4 form will constitute compliance with the reporting requirement.

For more information about this new reporting requirement, call Dave Furneaux at the IMS, 515/223-1401 or 800/747-3070.

Electronic medical records

IMS Services has endorsed an electronic medical records software package available through Healthcare Software Solutions, a Des Moines based company. The program is available to all Iowa physicians. For more information, call Barb Cannon at IMS Services, 515/223-2816 or 800/728-5398.

New ways to advertise your practice

The redesigned *Iowa Medicine* offers several effective ways to advertise your practice. The *Iowa Medicine Professional Directory* contains listings of Iowa physicians by specialty. Also, display classified ads are being offered for the first time in *Iowa Medicine*. For more information, call Jane Nieland at the IMS, 515/223-1401 or 800/747-3070. IM

For the first time, display classified ads are being offered in *Iowa Medicine.*

MMIC...Focus on Risk Management

"Experience has shown that aggressive risk management can prevent patient injuries and reduce malpractice claims," says Lori Atkinson, coordinator of risk management for Midwest Medical Insurance Company. "As a physician-owned company, MMIC is committed to helping physicians learn the skills to minimize their liability risks."

MMIC's risk management services are available to MMIC-insured physicians free of charge. Those services include:

•Individual consultations with experts in medicine, law and insurance who provide advice tailored to your practice.

•On-site risk management surveys by MMIC consultants to help identify potential problems.

•Malpractice claim prevention programs for clinics, specialty societies, hospital medical staffs and other groups.

•Physician-patient communication workshops accredited for CME which focus on the critical role of communication in avoiding malpractice claims.

For more information, contact Lori Atkinson, risk management coordinator, Midwest Medical Insurance Company, West Des Moines office, 800/798-9870 or 515/223-1482.

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Newsmakers

Looks forward to working with IMS

Dear Dr. Anderson:

I really enjoyed your "President's Privilege" in the October 1993 *Iowa Medicine.*

I look forward to working closely with IMS on issues of common interest and concern over the coming months and years and I am hopeful that our already close relationship will continue and, if possible, actually improve.

Again, I enjoyed your thoughts. Kindest personal regards.—*Stephen Brenton, President, Iowa Hospital Association, Des Moines, Iowa.*

Letter to the Editor

Our magazine is all wet

Dear Editor:

You kindly send us your journal in exchange for our *Journal of the Royal Society of Medicine.* We have just received the September 1993 issue, which has an article in it about psychological effects of the Great Floods. Ironically, the issue has got wet on its journey, so I write to ask if you could mail us a replacement.

I hope our journal is reaching you safely. With best wishes.—*Keith Nockels, Serials Librarian, London, England.*

Awards, appointments, etc.

Dr. Michael Kienzle, U of I cardiologist, has been appointed Coordinator of the Iowa Health Services and Education Telecommunications Network. This body will coordinate participation in the Iowa Communication Network. **Dr. John Olds,** has been chosen as medical director of Medicare Part B for Iowa. Dr. Olds will be retained by Blue Cross Blue Shield. **Dr. Joseph Veverka** is retiring from that position. **Dr. Henri Manasse, Jr.,** is the new vice president for health sciences at the U of I. Dr. Manasse, will oversee the colleges of Dentistry, Medicine, Nursing and Pharmacy and the U of I Hospitals and Clinics and Statewide Health Service Units. **Dr. Aeneid Chen,** obstetrics and gynecology; **Dr. Stuart Kolner,** dermatology; **Dr. Matthew Lawler,** obstetrics and gynecology; Dr. Paul Natvig, psychiatry; **Dr. David Carlyle,** family practice; and **Dr. Phillip Schmid,** anesthesiology, recently joined McFarland Clinic in Ames. **Dr. Steven Vince,** radiology has joined the McFarland Clinic in Boone. **Dr. Todd Gothard** has joined the Wolfe Clinic, PC in Cedar Rapids. **Dr. Emmett Wallace,** has been elected third vice president of the American Osteopathic Association. **Dr. Julianne Thomas,** received one of nine American Hospital Association Awards for Volunteer Excellence. Dr. Thomas, a pediatrician, is co-chairman of the Children and Adolescents Task Force of Healthy Linn 2000 and helped found the Safe Kids Coalition. **Dr. Ben Collins** has begun an internal medicine practice in Indianola. **Dr. Dale Christensen** has retired after 35 years of family practice in Lake City. **Dr. Judd Ott** has begun practice in Dubuque. **Dr. Randall Busch** recently joined Dubuque Anesthesia Services, PC. **Dr. Donald Kahle,** Dubuque, has been named a fellow of the American College of Radiology. **Dr. William Steinbeck** has retired after 30 years of family practice in Keystone.

Deceased members

Paul Boone, MD, 53, family practice, Rock Rapids, died July 9

Edward Grossmann, Sr., MD, 84, life member, family practice, Orange City, died September 27

Frank McCarthy, MD, 86, life member, family practice, Sioux City, died January 7, 1993

James Smrha, MD, 82, life member, family practice, Cedar Rapids, died October 18

Abraham Toubes, MD, 86, life member, internal medicine, Des Moines, died November 6 IM

AT A GLANCE

The annual Family Doctor of the Year award was presented to Dr. Francis Pisney, Iowa Falls, at the Iowa Academy of Family Physicians Annual Meeting at the Des Moines Marriott Hotel.

The newly-constructed Dr. Max Olsen Memorial Recreation Area at Kahler Park in Minden was recently dedicated. Dr. Olsen, a longtime Minden family physician, died in December 1992.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

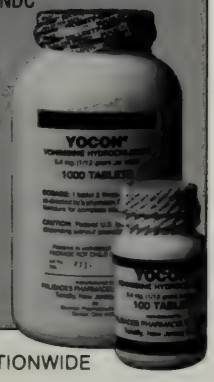
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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HEADING in a new direction

Health system reform may be down the road, but significant changes in the environment in which Iowa physicians practice are just around the corner. In the near future, the growth of managed care will have a profound effect on health care delivery. What are your options in this new environment?

Is there a clear course physicians should follow through the uncertainty pervading our health care delivery system? What paths are available and worth consideration? The direction you take depends on the circumstances surrounding your practice and your choice should be based on thorough investigation of every avenue open to you.

Two options merit consideration. One is "horizontal" economic integration with other physicians, particularly through formation of a medical group. The second is "vertical" integration with a hospital through creation of a Physician Hospital Organization (PHO) or similar entity.

A horizontal move

There are several basic models for a higher level of integration with your colleagues. Figure 1 on the next page illustrates the primary options for physician collaboration. On one end of the physician integration spectrum is solo practice; on the other is multispecialty group practice. The multispecialty group is a partnership or corporate structure through which physicians from various specialties combine interests and share the profits and expenses of a practice. Between these two extremes are other viable options including shared office arrangements, an Independent Practice Association (IPA), so-called "groups without walls" and single specialty groups.

The leap from solo practice to a large multispecialty group will be difficult.

Beware of quantum leaps

A large well-structured multispecialty group has considerable potential for taking advantage of managed care contracting. Certain economies of scale are available to large groups. In addition, physicians in these arrangements can provide a comprehensive array of medical services and are in a position to accept capitation payment.

The large group practice is an excellent example of large-scale physician integration involving sophisticated management and organization systems.

However, the leap from solo practice (or small single specialty group) to a large-scale multispecialty group will be difficult. Because of the many political and practical obstacles, the move into a large multispecialty group is usually a gradual process of physician integration which begins

THOMAS GOREY, JD
Mr. Gorey is president of Physician • Hospital Organization Services, Inc. of Crystal Lake, Illinois, a health care consulting firm which serves physicians, hospitals and other health-related organizations.

with much looser organizational ties. The most logical approach for Iowa physicians may be a smaller jump to the right along the integration continuum.

As an example, consider a solo practice physician with little experience in managed care. As a way to reduce overhead and take a first step toward formation of a group practice, this physician might identify several other physicians in similar practice circumstances (solo practice with little managed care experience) and with whom the physician enjoys a collegial relationship. These physicians may be interested in an agreement for shared office space, equipment, staff and ancillary services.

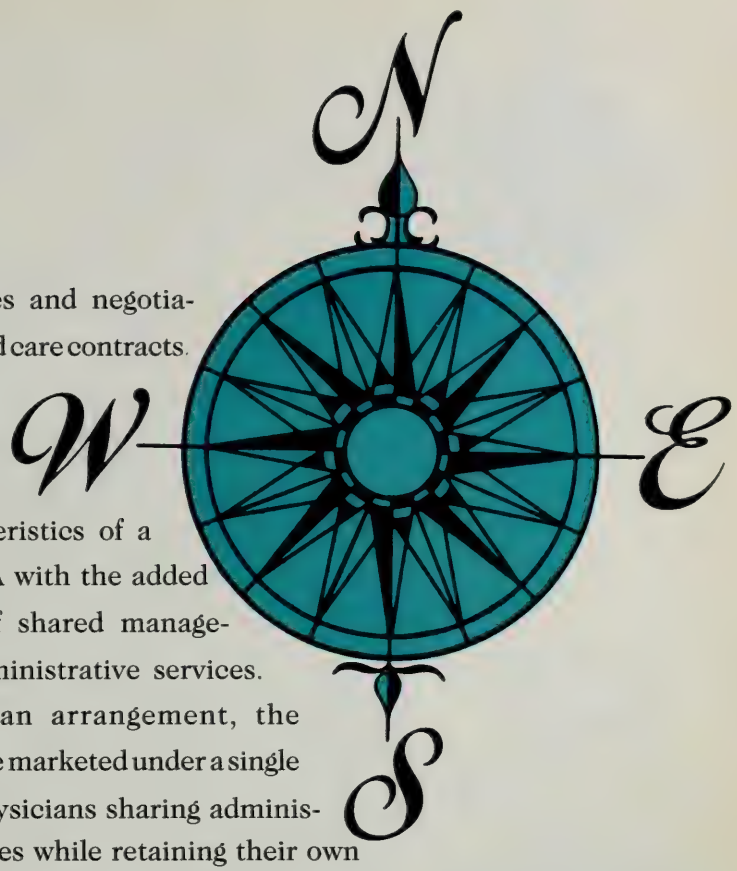
Though shared office space and other arrangements reduce overhead, they do little to promote practice development. Due to demands from payers, opportunities for managed care contracting are mushrooming. To take advantage of these, physicians may wish to consider an IPA.

Through an IPA, physicians can take full advantage of opportunities to build their patient base through participation in managed care contracts.

Clinics without walls

A relatively new phenomenon in the medical marketplace is the group practice without walls or "clinic without walls".

A clinic without walls is best defined as an arrangement between a previously unaffiliated group of physicians through which the physicians continue practicing in their own offices but have many benefits typically associated with group practice, including shared administrative services and negotiation of managed care contracts.



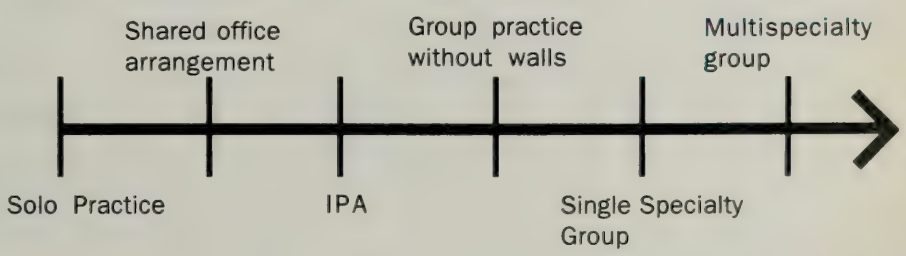
The group without walls incorporates some characteristics of a traditional IPA with the added component of shared management and administrative services. Under such an arrangement, the "group" may be marketed under a single name with physicians sharing administrative expenses while retaining their own revenues. In some cases, the sole difference between a group without walls and a traditional group practice is the fact that the physicians practice in separate offices.

Leadership potential in PHOs

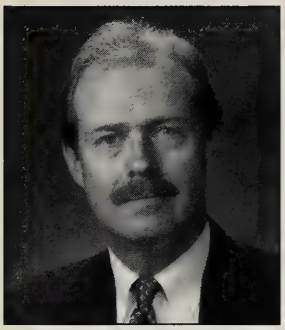
Another option in the changing environment is a closer affiliation with your primary hospital through a PHO or through some other cooperative business arrangement.

PHOs can be a way for physicians and hospitals to combine forces and take a leadership role in managed care delivery. A common first step in forming a PHO is to establish a physician-

FIGURE 1
PHYSICIAN INTEGRATION CONTINUUM



hospital planning committee. This committee is comprised of representatives of the hospital administration/board and the medical staff. The committee decides the PHO's function, structure and operations. Physician participation and input into the PHO is coordinated through the participating members of the medical staff. As Figure 2 demonstrates, the PHO is often structured as a not-for-profit corporation, with equal representation by the hospital and physicians on the board.



Prior to establishing Physician • Hospital Organization Services, Inc., Mr. Gorey spent 11 years on the staff of the American Medical Association. He was legislative attorney, director of physician practice services and director of long range policy analysis.

Medical staff not an economic entity

Despite the apparent simplicity of the medical staff PHO model, it is often advantageous for physicians to first form a Physician Organization (PO). A PO formed for the purpose of entering into a PHO agreement with a hospital can serve as an effective vehicle for providing physician input into the governance of the PHO.

Without a formal PO in place, the hospital medical staff becomes, de facto, the entity responsible for electing physician representatives to the PHO board, ongoing monitoring of PHO operations and policymaking on issues affecting physicians. The medical staff is not an economic entity and its governance process may not lend itself to efficient decision-making on business issues that arise.

Forming an IPA-type PO allows a core of physicians to create strategies designed to enhance their practices and put them into an advantageous position as a managed care provider group. A Physician Organization can also be an effective defense against "divide and conquer" strategies by payers and the hospital.

A PHO can be an effective defense against "divide and conquer" strategies.

Finally, an IPA may provide an opportunity for physicians to negotiate managed care contracts with PPOs, HMOs and self-insured employers.

Physicians forming a PO as a first step toward a PHO will incur operating and administrative expenses. A PO requires a board, a committee structure, staff support and a mechanism for credentialing, quality assurance and utilization review. There must be ongoing physician involvement and an effective governing process.

Forming a PO involves significant antitrust risks, The entity being created must have a legitimate business purpose. The physicians must be at financial risk and the entity cannot be created merely as a sham to engage in price-fixing. Formation of an IPA-type PO is one way to minimize potential legal problems.

Open or closed PHO?

One of the most important questions which must be addressed is whether the PHO should be open to all members of the medical staff or limited to those who meet certain quality and utilization criteria.

Although there may be political ramifications to excluding some physicians, it may be necessary to ensure the viability of the PHO.

Two problems can arise in an open PHO, where 60-90% of the medical staff might participate. Because of lack of selectivity, an open PHO may include physicians whose



utilization patterns will detract from the group's ability to secure and retain managed care contracts. Second, hospital medical staffs are usually dominated by specialists, while the effectiveness of a PHO depends largely on the existence of a strong primary care physician base.

The goal behind a closed PHO is to include only physicians with a demonstrated record of providing high quality, cost-effective care.

Clear message to physicians

The initial lack of reliable physician utilization data will make it difficult to apply selectivity standards to physicians who are interested in participating.

However, forming a closed PHO sends a clear signal that utilization data will be compiled on an ongoing basis and periodically shared with PHO physicians. Through regular recredentialing, the physician pool can eventually be narrowed to those whose practice patterns further the goals of the PHO.

Through careful planning, development of a sound legal structure and efficient governing process and implementation of effective participation criteria, it is possible to further the goals of the physicians and hospital while meeting the needs of payers. IM

Glossary of managed care terms

Physician Organization (PO): A business entity formed by physicians to pursue managed care contract opportunities. Examples are single and multispecialty groups, group practices without walls and IPA-type arrangements.

Physician-Hospital Organization (PHO): A business entity jointly formed by physicians and a hospital in order to pursue managed care contract opportunities. Shared governance and capitalization.

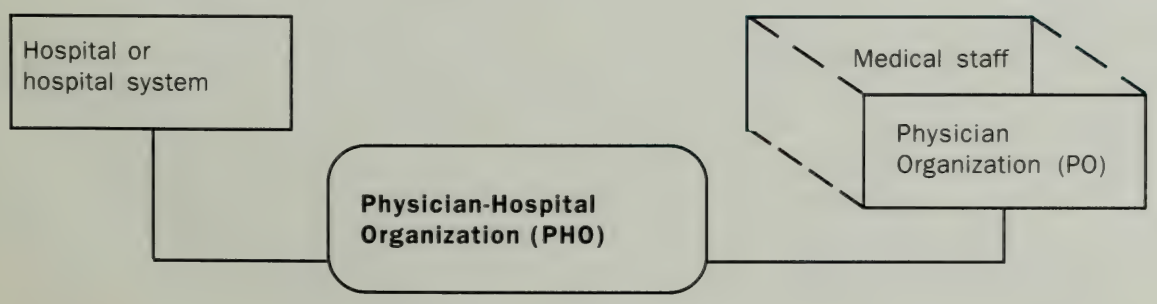
Independent Practice Association (IPA): An organization of independently practicing physicians formed for the purpose of contracting with an HMO. Physicians practice in their own offices, also providing care to non-HMO patients. The IPA pays physicians under capitation or fee-for-service arrangement.

Medical Group Practice: Provision of services by a group of at least 3 physicians engaged in a formally organized and legally recognized entity, sharing equipment, personnel, etc.

Group Practice Without Walls: A quasi group of independently practicing physicians who unite to take advantage of operating efficiencies through shared expenses while maintaining independent medical practices. The group can engage in centralized contracting with HMOs.

The pool can eventually be narrowed to those whose practice patterns further the goals of the PHO.

FIGURE 2
PHYSICIAN ORGANIZATION MODEL PHO



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The Journal
of the Iowa Medical Society

Low back pain resolution

● SHEILA MCGUIRE, DMSC; DANIEL MCGUIRE, MD

Medical management and outcome of low back pain (LBP) has far reaching implications in the workplace and society. LBP results in expenditures of $13 billion a year for medical care, is the second leading cause of work absenteeism, and the most expensive in terms of productivity losses.[1,3]

Most disk herniations are resolved without surgical intervention. It is estimated that 5%-10% of patients with persistent sciatica will require surgery.[5] However, the rate of lumbar discectomy actually rose 53% between 1980 and 1985.[2] Controlled trials show a better result in well-selected candidates for surgery at 1-year follow-up but differences are inconclusive at 4 and 6 years.[8]

The objective of our study is to describe the patient population with low back pain visiting an orthopaedic office specializing in back problems. Variables include sociodemographic and physical characteristics at initial examination, treatment course, patient satisfaction, rate of work absenteeism and compensation status.

One hundred patients reviewed

A medical record review was performed on all new patients presenting with low back pain during October, 1991. Sociodemographic variables, physical characteristics and status of diagnostic tests were reviewed. A telephone survey recorded work absenteeism rates and levels of patient satisfaction. The medical records of all patients seen in October were reviewed for smoking history and workers' compensation status.

One hundred new LBP patients were seen during the month under study. Medical records for 69 of the new patients were retrievable for review. Thirty-six patients (52%) were non-workers' compensation (NWC) patients and 33 (48%) were covered by workers' compensation (WC). In both NWC and WC populations, approximately 40% were seen within 3 months of initiation of severe pain and 30% were seen 1½ years or more since the incident.

Eleven percent of NWC patients smoked and 64% of WC patients smoked. An assessment of smoking history was conducted for all patients seen in October. The proportion of NWC smokers remained at 11% but the proportion of WC smokers increased to 70%. Stratification of smoking status by leg pain presence within the 2 populations was conducted. In the WC population with leg pain, 66% smoke. Only 20% of the NWC population with leg pain smoke.

Work absenteeism

Thirty-nine percent of the NWC population missed no days of work; 9% of the WC population missed no days of work. Seventeen percent of the NWC population self-reported missing 1-10 days and another 17% self-reported missing 11-30 days of work. The majority of the WC population (67%) missed more than 30 days of work. Eighty percent of the WC patients with radiating leg pain missed 30 or more days of work. In contrast, 40% of the NWC with radiating leg pain missed no days of work.

Fewer radiographs were ordered in the WC population than in the NWC population. Every fourth WC new patient arrived with a pre-existing MRI and every tenth with a CT scan. Very few NWC presented with any pre-existing scans.

Regimens available for initial treatment of LBP include physical therapy, prescription

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for January 1994.

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Dr. McGuire practices with Des Moines Orthopaedic Surgeons, PC.

Low back pain resolution

continued

drugs, over the counter medications, exercise and smoking cessation advice. Physical therapy was prescribed for 42% of the WC patients and 14% of the NWC population. The other courses of treatment depend on patient compliance.

Objective data on the implementation of the suggested course of treatment is difficult to compile. Follow-up telephone calls to the NWC patients were placed to quantify compliance with the treatment plan and to measure patient satisfaction. No one reported compliance with an exercise regimen but most had filled and taken prescription drugs. Almost half the NWC patient population reported a better activity level since treatment and 39% reported an activity level similar to that prior to the office visits.

Number of visits following the initial examination was recorded for the period between October and the end of December. The majority of the NWC population, 83%, were seen once; 60% of the WC population were seen once and 27% were seen 3 or more times. Of the NWC population, over 66% had not visited any other health care professionals after the appointment(s). Of those NWC patients who reported further care, 6 had seen a chiropractor and 4 had since seen another medical doctor.

Treatment studies needed

Future studies are needed to determine the most effective treatments to decrease disability resulting from low back pain. The studies should stratify populations by workers' compensation status due to the trends reported in this study. The 2 populations were similar in terms of age, time since injury and percent with leg pain. Documentation confirms that these variables related to type and severity of injury would be similar across referral patient populations. Similar percentages of patients required expensive diagnostic testing. However, a plain radiographic series was ordered less frequently in the workers' compensation population than in the non-workers' compensation population. A reverse was anticipated due to the litigious nature of workers' compensation claims. However, the WC population presented with higher rates of pre-existing imaging scans.

Additional differences emerged between the 2 groups of patients with LBP. Dramatic differences exist in the number of smokers; but smoking does not have a consistent effect on the proportion suffering from radiating leg pain. Radiating leg pain does seem to affect the ability to return to work in the WC population (80% missed more than 30 days of work) more than in the NWC population (33% missed no days of work). Without regard to leg pain status, work absenteeism was significantly higher in the WC than in the NWC.

Two recent reports on management of LBP support the importance of exercise and the resumption of activities as the route to the resolution of LBP. Fordyce et al found that patients permitted to decide activity level felt more sick at followup than a similar group of patients who had been given instructions by their physicians as to level of activity.[4] Waddell concluded active rehabilitation restored function, reduced distress, promoted return to work and reduced pain.[7]

As 85% of LBP is of unknown cause, the clinician's time may best be spent eliciting history and physical factors that influence therapy. As has been noted by many researchers, objective findings at initial examination are usually not predictors of the success/failure in resolving LBP. Behavioral perspectives in viewing pain must be incorporated. Approaches are also needed to improve patient compliance with exercise plans and smoking cessation. Patients, health care providers and researchers should work together to improve the functional level of patients suffering from debilitating pain, help eliminate inappropriate treatment regimens that drain precious resources and reduce the incidence of low back pain.

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References noted in this article are available from the authors or the editors of *Iowa Medicine*. IM

Trisomy 22 in an Iowa newborn

● *Sergio Golombek, MD; Robert Shaw, MD*

This is a case report of complete trisomy 22 in a 29-week gestational age white male with multiple malformations (Figure 1). The karyotype of the patient (cytogenetic report using GTG banding) showed 47, XY, +22, consistent with a male carrying an extra chromosome 22 (Figure 2). This is the third reported case combining a trisomy 22 and a congenital diaphragmatic hernia.

Inadequate prenatal care

The baby was born at 29 weeks gestation to a 16-year-old gravida 1, now para 1, white single mother. Prenatal care was instituted at about 25 weeks gestation. The initial ultrasound examination was suspicious for multiple anomalies including congenital diaphragmatic hernia, possible hypoplastic left heart syndrome and neck swelling.

The mother was to be referred to the University of Iowa for comprehensive fetal evaluation on the week in which the baby was born, but she presented on the evening before the delivery with labor and leakage of amniotic fluid. The infant was born by spontaneous vaginal delivery and electively intubated with great difficulty secondary to neck swelling.

Obvious multiple congenital anomalies were noted, including a malformed rudimentary left ear with anterior dimple, cleft palate and diffuse neck swelling. Flexion contractures of the elbows, knees and hips were noted. Few skin creases were evident, suggestive of little or no fetal movement. There was also evidence of dextrocardia and brachicephaly. Poor response to mechanical ventilatory support suggested a congenital diaphragmatic hernia and possibility of congenital heart disease. The abdomen was scaphoid. Testes were present in the inguinal canal. Mild hypospadias and position deformities of both feet were noted. Apgar scores were 1 at one minute and 2 at 5 minutes.

There was no response to intubation or mechanical ventilatory support. The heart rate was less than 40. Color was poor. The baby expired at 65 minutes of life of cardiorespiratory arrest. Blood was drawn for chromosomes and blood culture. Consent for com-



Figure 1. Gross appearance of reported patient.

Sergio Golombek, MD
Robert Shaw, MD
Dr. Golombek did a pediatrics residency at Blank Children's Hospital in Des Moines and is doing a fellowship in neonatal-perinatal medicine at Children's Mercy Hospital in Kansas City. Dr. Shaw is a neonatologist at Iowa Methodist Medical Center.

Trisomy 22 in an Iowa newborn

continued

plete autopsy examination without restrictions was obtained from the infant's mother.

Gross autopsy description

Measurement: Crown-heel length 37 cm; crown-rump length 27 cm; head, chest and abdomen measured 27.5 cm, 23.5 cm and 21 cm in circumference respectively.

Weight: 1360 gm

Head and Neck: Abundant vernix caseosa over the scalp. No hair was noted, however. The scalp and facies were plethoric. Examination of the eyes and orbital areas revealed no obvious congenital anomalies. A fairly large cleft palate was evident. In the left cheek area, 3 mm papular lesion was noted with depressed circumferential margins. Malformed left ear consisting of only a rudimentary ear lobe.

Thorax: External examination of the thorax was unremarkable.

Abdomen: The abdomen was scaphoid; both testes undescended. Suggestion of a mild hypospadias.

Extremities: Extremities were grossly unremarkable and all digits present. Both feet were dorsiflexed.

Dorsum of body: The anus was perforated. The dorsum was unremarkable except for fairly marked dependent congestion/plethora.



Figure 2. Karyotype of patient demonstrating trisomy 22.

There was an area of prominence of the distal sacrum including a small "dimple" in the midline measuring about 1 mm.

Internal examination

Thorax: A large diaphragmatic hernia was present. The defect in the diaphragm measured approximately 3 cm in diameter. Included among the organs present in the thorax were the entire left lobe of the liver, the stomach, the spleen, the cecum, most of the transverse colon and nearly all of the small intestine. Only a small amount of what appeared to be the proximal small intestine and distal colon were present in the abdominal cavity. There was no pneumothorax or pleural effusion or pericardial effusion.

Cardiovascular system

Heart: Weight was 7.5 gms. The lateral aspect of the right ventricle wall measured up to 6 mm. The right ventricle was small and appeared hypoplastic. The left ventricle was normal in size, with its ventricular wall measuring up to about 4 mm in thickness. No ventricular septal defects were evident.

Blood vessels: No congenital anomalies of the great vessels or the aortic arch were evident.

Respiratory system

Lungs: The right lung weighed 4.7 gms, left weighed 3 gms. Both lungs were extremely hypoplastic secondary to the herniation of much of the intra-abdominal contents through a large defect in the diaphragm. It was apparent that compression of both lungs had occurred by this latter mechanism. The pleural surfaces of both lungs were otherwise smooth and pinkish-red in color. On cut section the lungs had a meaty, homogenous, pinkish-red interior.

Gastrointestinal tract

Esophagus: Esophagus was grossly unremarkable.

Stomach: The stomach was situated in the thoracic cavity, with an otherwise normal appearance.

Small intestine: Most, if not all, of the small intestine was present above the diaphgram in the thoracic cavity, with an otherwise grossly unremarkable appearance.

Appendix: Appendix was present in the usual location with relationship to the cecum, although the appendix and the cecum were located within the thoracic cavity.

Colon: Except for the descending colon and rectum, the entirety of the colon was present in the thorax. On cut section the colon was filled with dark green meconium. No abnormalities were identified.

Mesentery: Most of the mesentery was present intra-thoracically with a grossly unremarkable appearance.

Pancreas: Pancreas weighed 1.5 gms and was situated in the usual location in relationship to the stomach and duodenum, although also was located within the thoracic cavity.

The hepatobilary system, urogenital system, hemolymphatic system, musculoskeletal and endocrine systems were grossly unremarkable. No specific abnormalities were identifiable in the brain.

Microscopic examination

The final autopsy report summary shows that the proband died secondary to severe pulmonary hypoplasia resulting from a large diaphgramatic hernia.

Karyotyping performed from the peripheral blood of the infant by GTG banding revealed trisomy 22 and several congenital anomalies associated with trisomy 22 in the literature were noted in autopsy. Particularly noteworthy was the presence of a malformed left ear with absence of external ear canal, which is seen in a high proportion of infants with trisomy 22. Congenital diaphramatic hernias have not been associated with trisomy 22.

Discussion

Trisomy 22 is a rare clinical syndrome complicating 1 in 30,000 to 50,000 live births. Trisomy 22 is a frequent finding in spontaneous abortions and is rare and generally incompatible with term pregnancy or normal extrauterine survival. The case presented here involved a 16-year-old mother, but the majority of cases of complete trisomy 22 have been associated with advanced maternal age (35 years), attributed to nondisjunction. Characteristics in these cases included severe intrauterine growth retardation and intra-renal malformations, gut malrotation, anal atresia and short post-natal survival. A routine chromosome study of over 78,000 patients at the University of Leuven, Belgium showed no single case of complete nonmosaic trisomy 22. The oldest individual with trisomy 22 on record is a 20-year-old reported by Welter in 1978.

The main clinical manifestations of complete apparently nonmosaic trisomy 22 are growth retardation, hypotonia, microcephaly, hypertelorism, epicanthus, antimongoloid slant, apparently low-set malformed ears, micrognathia, congenital heart defect and short postnatal survival.

The most frequent etiology of trisomy 22 is maternal non-disjunction at first meiotic division with a strong dependence of mother's age. In our case the father was not involved and, since the family did not wish him to know about the baby, we were unable to perform karyotyping studies. Fibroblast cultures could not be obtained in a timely manner.

The congenital abnormalities of the syndrome include microcephaly, long philtrum, micrognathia, long and beaked nose, cleft palate, low set and/or malformed ears, preauricular skin tags or sinuses, congenital heart defects, underdeveloped musculature and/or hypotonia, long slender fingers and/or finger-like thumbs and congenital hip dislocation.

Additional common findings are cranial facial asymmetry, frontal bossing, hypertelorism, strabismus, antimongoloid slant of the eyes, hypoplastic and/or low-set nipples and cryptorchidism in males.

The frequency of chromosomal abnormalities in newborns is 6:1000. The rarity of trisomy 22 in newborns — described as less than .5% of all anomalies — suggests that only 1 in every 1455 fetuses with trisomy 22 conceived is carried past 20 weeks.

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A new era for *Iowa Medicine*

The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.

Franklin D. Roosevelt

The mission of *Iowa Medicine* magazine is to give IMS members the information they need. However, if we are to continue meeting our members' needs, we must keep pace with the changing times.

With that goal in mind, the IMS Strategic Planning on Communications and Image recommended a number of changes in the Society's communication program.

One of those changes is the redesigned *Iowa Medicine* which you have before you.

Surveys show our journal is well read, but the physicians who served on the strategic planning committee felt strongly our magazine should be able to compete more effectively with specialty journals as a prestigious publishing opportunity.

To further this goal, an *Iowa Medicine* Scientific Panel has been formed. This panel is comprised of physician representatives of specialty groups who are charged with finding scientific articles in their specialties which provide useful information for all Iowa physicians.

One purpose of *Iowa Medicine* is to provide a publishing opportunity for Iowa physicians, and these physician authors can be assured that articles published in *Iowa Medicine* will continue to appear in *Index Medicus*. Although we continue our close cooperation with the faculty of the University of Iowa College of Medicine, this does not preclude the need for state-of-the-art scientific articles from physicians practicing across Iowa. This printed forum is one of the privileges of membership in the IMS.

As you can see, the new *Iowa Medicine* blends the scientific with the socioeconomic in a new format. Current information in health system reform, medical economics, practice management and other areas has previously been disseminated to members in the form of four newsletters.

Henceforth, members have the security of knowing that all this information can be found in one source — *Iowa Medicine.*

In addition, we are finalizing plans to include a bi-monthly insert in the magazine which will be directed at patients. An attempt is being made to cover topics of wide interest among patients. Physicians will be free to copy these inserts for their reception areas or order reprints if they wish.

Articles published in *Iowa Medicine* will continue to appear in *Index Medicus.*

We hope you approve of the changes we have made in your magazine. The editors of *Iowa Medicine* pledge to do the best job we can to give you current information in a readable, eye-catching format. We invite your comments. IM



Marion Alberts, MD

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AIR FORCE

Gold rush medicine

Sophisticated persons don't believe that history predicts the future, but they generally grant that studying history provides useful perspective. Further, if travel is indeed "broadening", as is often proclaimed, then travel to a place where one learns of history must be particularly beneficial.

On a recent trip to Seattle, I visited the U.S. Park Service museum that presented the story of the great Klondike gold rush of 1896-98. All miners passing through Seattle who sought gold nuggets and ore of the harsh, lonely northern Yukon were obliged by Canadian authorities to carry with them a year's supply of provisions and equipment. A small component of the required merchandise was medical: 25 cents worth of Cascara Sagrada (sacred) bark; 1 bottle good whiskey; 3 boxes carbolic salve; 1 bottle arnica.

The purpose of the Cascara seems definite — it has a mild laxative effect. When percolated 1:1 with water, the adult dose would be 2-4 ml. (I have access to some interesting old pharmacology textbooks.)

Whiskey may have been thought useful if the circulation or respiration needed stimulating. Even by the sixth edition of Cushny's text (1915) that idea was well outmoded, the main use being its narcotic action.

Carbolic (phenol) salve can still be bought at the drug store. In a strength of 1-2% it may help prevent common skin infections or help treat them; at least, it was well known to have antiseptic properties, which is why Lister had been spraying it into wounds and the air of surgical amphitheatres. Modern antibiotic salves have not totally replaced the old phenolated Vaseline.

Arnica probably referred to a tincture derived from the dried flower heads of *Arnica montana.* It was a counter-irritant, once popular for sprains, bruises and surface wounds. There is still an active market for liniments, unless we've really gone "modern" and use acupuncture when we feel the need of counter-irritation. At a large drug store, you can still buy these products.

If you or I, working as enlightened practitioners of that day, had been charged with drafting the list of medical requirements, would we have altered that list? It's hard to project oneself into an earlier time and not carry with us what we think we have learned in the meantime. What would you or I suggest for someone headed into a solitary, subarctic environment? What if we were constrained to list only four items?

What would you or I suggest for someone headed into a solitary, subarctic environment?

What perspective does historical information provide for the present? We'll each have our own answers, of course. Maybe one worthwhile effect would be to reduce our excessive confidence (arrogance, maybe?) in our contemporary preventive and therapeutic tools. We might ponder how primitive our era will seem a century hence — maybe something like the way we feel toward the therapists of the early 1800s, now notorious because of their fondness for pushing large, dangerous doses of opiates and mercury. IM



Richard Caplan, MD

Classified Directory

Family Practitioner—Needed to join the prestigious Mercy Family Care Network (MFCN). MFCN, a subsidiary of North Iowa Mercy Health Center, Mason City, Iowa links primary care clinics in a 13-county area to provide quality accessible health care services. An opening has become available in one of MFCN's facilities for a BE/BC family physician. The Kossuth Family Health Center, Algona, Iowa is a group of 3 board certified family physicians striving to increase the size of their practice. Their practice is located at Kossuth County Hospital. The newly renovated hospital experiences a strong patient base and is financially above average compared to all other Iowa rural hospitals. Algona, Iowa is a beautiful community with diversified light industry and agriculture. All of the major employers have experienced tremendous growth in the past 3 years. This community is an excellent place to raise a family. To learn more about this unique opportunity and the Mercy Family Care Network, please contact Laura E. Weis, Mercy Family Care Network Representative, 4500 Westown Parkway, Suite 250, West Des Moines, Iowa 50266; 515/224-3260.

Acute Care, Inc./Emergency Medicine/Locum Tenens—Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Emergency Medicine—Outstanding professional opportunities in emergency medicine available in a variety of great Iowa locations. Quality lifestyles in family oriented communities. Comprehensive compensation packages for primary care trained or experienced emergency physicians. Administrative and staff positions with a progressive, physician owned contract staffing group. For immediate consideration call Sheila Jorgensen at 1-800/458-5003 or mail CV to Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704.

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General Surgeon—Wanted to join primary care group of 8 established physicians with a captive on-site referral base. This position offers outstanding professional, financial and lifestyle opportunities with outstanding school system. Please call Linda Cohrt, Family Medical Center, 515/673-6762 or mail CV to 1225 C Avenue East, Oskaloosa, Iowa 52577; fax 515/672-2258.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Corning, Iowa—Superior family practice opportunity in lovely and prosperous SW Iowa 80 miles from Omaha and Des Moines and 12C from Kansas City. The BE/BC FP will associat with BC FP and BC internist in "All American City" with Mercy Hospital affiliation. Mercy Hospital is a 35-bed non-profit facility. Corni has great schools, low cost housing, abundant outdoor recreational activities including numerous lakes for fishing and water sports, outstanding hunting, a country club with a 9-hole golf course, an airport and a great public library which has recently benefited from a one-half million dollar addition. Recruitment package includes aggressive first year guarante including signing bonus and relocation benefit Call Steve McNeill now at 402/398-6658 for information or fax CV in confidence to him at Mercy Midlands, 402/398-6032.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physician in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 55 doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, cal Roger Greenwald, Executive Vice President or Dr. B. C. McGregor, President, at 507/625-181 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Immediate Opening—One internist or family practitioner (internist preferred) at a 200-bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $74,640.00. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, M.D., Superintendent, Mental Health Institute, Independence, Iowa 50644. Telephone: 319/334-2583. An Equal Opportunity/Affirmative Action Employer.

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to Strelcheck & Associates, Inc., 10624 N. Port
Washington Road, Mequon, Wisconsin 53092.

Family Practice, Madison, Wisconsin—Dean Medical Center, a 250-physician multispecialty group, is seeking additional family physicians to join its 30-member department. Positions are located at our Madison, Marshall and Evansville locations. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreational opportunities are available year round. Excellent compensation and benefits are provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Highway, P.O. Box 9328, Madison, Wisconsin, 53715-0328, work 1/800-279-9966, 608/259-5151 or home 608/833-7985. An Equal Opportunity Employer.

Gastroenterology, Neonatology, Neurosurgery, Occupational Medicine, Oncology, Orthopedics, Orthopedics-Hand—Strelcheck & Associates Inc., an extension of our clients recruiting departments, has positions available in Wisconsin, Michigan, Ohio and West Virginia. We would be happy to provide you with further information. Please call 1-800/243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, Wisconsin 53092.

Family Practice Physician—Needed for spectacular Iowa city of 13,000. Retiring general practitioner will leave full practice for new physician. New hospital and medical offices, good call sharing, excellent income guarantees, signing bonus. Top schools and lovely family community. Contact Julie Sherriff, Sherriff & Associates, 10983 Granada #202, Overland Park, Kansas 66211. 1/800-533-0525, fax 913/451-3931.

Internal Medicine, Madison Wisconsin—Dean Medical Center, a growing 250-physician multispecialty group with over 21 locations, is seeking additional BE/BC internists to join their 25-member department. Opportunities are available at our clinics in Stoughton and Sun Prairie. Madison is the home of the University of Wisconsin with enrollment of over 40,000 students and the state capital. Abundant cultural and recreations opportunities are available year round. Excellent compensation and benefits provided with employment leading to shareholder status. For more information contact Scott M. Lindblom, Dean Business Office, 1808 West Beltline Highway, P.O. Box 9328, Madison, Wisconsin 53715-0328, work 1/800-279-9966, 608/259-5151 or home 608/833-7985. An Equal Opportunity Emoloyer.

Cedar Rapids, Iowa—Established all emergency medicine boarded group seeking BC/BP emergency physician to join 6-member group. Brand new ED, highly trained staff, approximately 35,000 ED census. Will be double coverage with 8-hour shifts. Competitive compensation package. Contact: 319/398-6047 or send CV to Mercy Trauma Physicians P.C., 701 10th SE, Cedar Rapids, Iowa 52403-1251.

Council Bluffs, Iowa—BC/BE internist and pediatrician needed for expanding multispecialty group serving 300-bed Mercy Hospital. Young medical staff and modern facilities adjacent to hospital. Established group currently has 2 BC internists and 2 BC pediatricians. BC/BE FPs also needed for both single specialty and multispecialty groups. Council Bluffs, population 54,000, has excellent schools and housing and is within easy access to wonderful recreational and cultural activities, including a large and beautiful lake for water sports, ballet, symphony, opera and professional theater. All opportunities offer competitive compensation and benefits including relocation. Call Steve McNeill now at 402/398-6658 or fax CV in confidence to him at Mercy Midlands, 402/398-6032.

Family Practice, Minnesota—BC/BE family practitioner to expand current 23-member department. Enjoy a lifestyle of call every 21-23 days and an average 4-day work week. Just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of our physician-owned and directed group earn a highly competitive income and excellent benefits including paid vacation and CME, pension plan, all insurances paid and partnership potential after one year. Please respond with CV to John Pastorius, M.D., Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-9155.

Orthopedic Surgeon—Needed to take over practice of disabled physician and associate with fellowship-trained orthopedic surgeon. Spectacular Iowa community with top schools and lovely housing. New hospital and medical offices, good call sharing, first year $250,000+. Contact Julie Sherriff, Sherriff & Associates, 10983 Granada #202, Overland Park, Kansas 66211. 1/800-533-0525, fax 913/451-3931.

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Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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John A. Caffrey, MD, PC
1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
1701 22nd Street, Suite 201
West Des Moines 50265
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
Practice Limited to Disease, Cancer and Surgery of Skin

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Electrodiagnosis

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Locum Tenens
Doctor on Call

Infectious Diseases

Chest, Infectious Diseases & Critical Care Associates, PC
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
Neurology, EEG, EMG, Evoked Potentials and Sleep Studies

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurosurgery

Iowa Medical Clinic Neurosurgery
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
Schoitz Medical Arts Center
2600 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756
Practice limited to Neurosurgery

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
1215 Pleasant, Suite 608
Des Moines 50309
515/283-5760
Neurological Surgery

Des Moines Neurosurgeons, PC
Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
2600 Grand Avenue, Suite 210
Des Moines 50312; 515/283-2217

Ophthalmology

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
540 E. Jefferson, Suite 201
Iowa City 52245
319/338-3623

Fox Eye Institute
Lee Birchansky, MD
1953 1st Avenue, Cedar Rapids 52402
1400 7th Avenue, Marion 52302
1-800/I SEE YOU

Timothy F. Moran, Jr., MD
2800 Pierce, Suite 106
Sioux City 51104
712/252-4333
General Ophthalmology

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Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
Timothy P. Sullivan, MD
309 East Church
Marshalltown 50158
515/754-6200

Satellite Offices
Lakeview Medical Park
6000 University Avenue, Suite 300
West Des Moines 50266
515/223-8685

804 South Kenyon Road, Suite 100
Fort Dodge 50501
515/576-7777

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
Earl R. Elowsky, MD
Timothy W. Neff, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Otolaryngology

Dubuque Otolaryngology Service, PC
Thomas J. Benda, MD
James W. White, MD
Craig C. Herther, MD
310 North Grandview
Dubuque 52001
319/588-0506

Iowa Head and Neck Associates, PC
Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
3901 Ingersoll
Des Moines 50312
515/274-9135

Oto.–Head & Neck Surgical Associates, PC
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Steven R. Herwig, DO
Mark K. Zlab, MD
1215 Pleasant, Suite 408
Des Moines 50309
515/241-5780
1-800/248-4443
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

Robert G. Smits, MD, PC
1040 5th Avenue
Des Moines 50314
515/244-8152
1-800/622-0002
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Phillip A. Linquist, DO, PC
1000 Illinois
Des Moines 50314
515/244-5225
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Michael W. Hill, MD
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309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
6000 University Avenue, Suite 300
West Des Moines 50266
515/224-9533

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516 South Division Street
Cedar Falls 50613
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Dubuque Anesthesia Services, PC
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Rolando G. Cuevas, MD
Robert L. Gallogly, MD
1890 John F. Kennedy Road
Dubuque 52002
319/556-7542
fax 319/556-8334

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Rehabilitation Medicine Associates
William D. DeGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Younkers Rehabilitation Center
Iowa Methodist Medical Center
1200 Pleasant
Des Moines 50308
515/283-6434

(Continued next page)

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Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Mercy Hospital
1401 West Central Park Avenue
Davenport 52804-1769
319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
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Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Ronald L. Rains, MD
Pulmonary Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hour 515/224-1777

Fort Dodge Medical Center, PC
Robert C. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Surgery

Sinesio Misol, MD
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400
Orthopedic Surgery, Surgery of the Hand

Wendell Downing, MD
1212 Pleasant Street, Suite 410
Des Moines 50309
515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC
Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

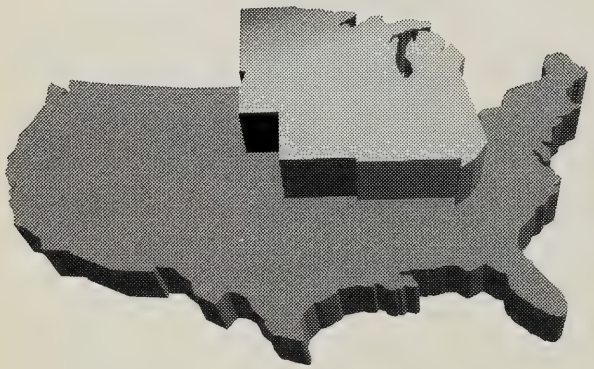
Urology

Fort Dodge Medical Center, PC
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Fort Dodge 50501
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How the BME helps ensure quality care

The Iowa State Board of Medical Examiners is the regulatory body for Iowa physicians, but not all physicians understand how the BME process works. In an earlier column, I discussed the Board's licensing procedure; this month, I focus on the board's disciplinary function.

Besides a Licensing Committee, there are three other BME committees: *Liability Insurance, Screening and Intake* and *Discipline*. The Iowa Insurance Commissioner is required by law to report malpractice cases to the BME.

These cases are reviewed by the Liability Committee, which looks for a pattern of malpractice. The committee members may request additional information from the physician. Based on this committee's recommendation, the full board either closes the case or sends it to the discipline committee.

All other complaints received by the BME go to the Screening and Intake Committee, which sets an order of priority for the cases from routine to urgent complaints requiring immediate investigation. The committee directs the BME investigators regarding what type of information is needed. Based on the investigator reports, the Screening and Intake Committee makes a recommendation to the full board.

If the Screening and Intake Committee decides a problem exists, the case is referred to the Discipline Committee. The Discipline Committee reviews the file and can ask investigators for more information or ask a physician to appear voluntarily before the committee.

The physician may also request a meeting with the BME executive director or the Disciplinary Committee at any time during this process. This is one of the safeguards which ensures physicians are treated fairly and receive due process during the investigation.

When all necessary information has been obtained, the Discipline Committee makes a recommendation to the full board. If the board elects to close the file or close the file with a letter of reprimand or warning, the entire process remains confidential.

If the board chooses to file a complaint and statement of charges, the matter becomes public. That's when the physician's name ends up in the newspaper.

If the board elects to file charges against the physician, the matter becomes public.

A hearing is then scheduled before a three-person panel of board members. An administrative law judge presides over the hearing. A physician definitely needs an attorney at this point, and the State is represented by an assistant attorney general.

The decisions of the panel are final. However, they can be appealed to the full board and on through the court system. Some cases go as far as the Iowa Supreme Court.

I hope this synopsis helps you understand better how the BME strives to treat physicians fairly and ensure quality care for Iowans. IM



John Anderson, MD

IMS Update

AT A GLANCE

An Open Forum on Health System Reform will be held Saturday, April 16 in conjunction with the 1994 IMS Annual Meeting. Check the ***Health System Reform*** *section for more details.*

Thirty-eight Iowa legislators participated in the 1993 IMS Alliance Mini-internship program. The lawmakers each spent a day in a physician's office and accompanied the physicians on hospital rounds.

The IMS has endorsed a survey of Iowa physicians by the Iowa Department of Public Health regarding breast and cervical cancer screening facilities. The purpose of the survey is to identify gaps in screening services.

The IMS Subcommittee on Psychiatric Care will meet Thursday, February 17 at IMS headquarters to discuss restructuring of mental health delivery system.

New law affects dues deductibility

A new provision in OBRA 1993 will affect deductibility of IMS and AMA dues in 1994 and subsequent years.

Under the provision, the portion of dues attributable to certain lobbying and political activities conducted by associations will no longer be deductible as a business expense. As a result, 19% of IMS dues and 23% of AMA dues for 1994 cannot be deducted as a business expense for federal income tax purposes.

No portion of any dues paid to AMPAC or IMPAC may be deducted as a business expense or as a charitable contribution for federal income tax purposes. Contributions to the IMS Education Fund are tax deductible.

The American Society of Association Executives has filed a federal lawsuit challenging the constitutionality of the provision.

Final dues notice will be sent

The fourth and final IMS/AMA dues notice will be sent to members in mid-February. Dues are considered delinquent on March 1. Prompt payment of your dues will be appreciated.

Physician Award for Community Service

IMS continues seeking nominees for its Physician Award for Community Service. This newly-created award will be presented during the 1994 House of Delegates.

The award will honor an Iowa physician who has provided outstanding civic, charitable and health services to patients and the community.

Anyone can nominate a physician by writing to the Physician Community Service Award Committee at the Iowa Medical Society. The letter should provide the physician's name and address, a picture of the physician and a description of the nominee's service and why he or she should receive the award. The deadline for nominations is April 1.

Physician response to Minnesota Tax

The state of Minnesota is attempting to tax certain revenues of out-of-state physicians who treat Minnesota patients. The tax is effective for services performed as of January 1, 1994.

Some IMS members have already received postcards from Minnesota asking them to identify the staff member with responsibility for seeing the tax is paid.

Background

The MinnesotaCare Act imposes a tax on the gross revenues received by physicians and hospitals for services provided to Minnesota patients.

For physicians outside Minnesota, the tax is 2% of the money they receive for treating Minnesota patients. Medicare and medical assistance payments are exempt.

The state of Minnesota says you are subject to the tax if you solicit patients in Minnesota, treat 20 or more Minnesota residents annually or regularly perform services outside Minnesota "the benefits of which are consumed in Minnesota".

The tax applies even if only one of these conditions are met. You are allowed to raise

Specialty Society Update

The Iowa Academy of Otolaryngology notified its members that implementation of Medicare's RBRVS for 1994 could result in as much as a 10% reduction in reimbursement for some ENT surgical services.

The Iowa Medical Group Management Association's Spring Meeting will be May 4-6, 1994 at the Des Moines Marriott Hotel.

The Iowa Association of Long Term Care Facility Medical Directors has received a grant from Hoechst Celanese Pharmaceuticals to provide on-site planning assistance for members.

The Iowa Psychiatric Society is considering creation of a statewide mental health public relations consortium.

your fees to cover the tax but may not itemize the tax on patient bills.

Minnesota tax deadlines

If you or your practice are subject to the tax, you are required to file a tax return by March 15, 1995. If your tax liability is $500 or more during 1994 (in other words, if your gross revenues for treating Minnesota patients is expected to exceed $25,000), you are required to pay quarterly estimated taxes. The first installment is due April 15, 1994.

The IMS is participating in a lawsuit filed on behalf of eight physicians who are challenging the constitutionality of the tax as applied to out-of-state providers. The court interpreted the statute to prevent physicians from suing until the state of Minnesota attempts to collect the tax. That decision is being appealed.

Responses to the tax

Some Iowa physicians have received notification from the state of Minnesota that they are expected to pay the tax. You have two choices: you can pay the tax or you can contest it on constitutional grounds. There are two ways to challenge the tax: 1) Pay the tax and sue for a refund in Minnesota trial court; 2) Do not pay the tax and file suit in Minnesota court if it is assessed against you.

You must make an independent decision about how to respond to the tax. If you have questions regarding the tax, call Tim Gibson at the IMS, 515/223-1401 or 800/747-3070.

PRO Advocacy Committee to meet

The Iowa Medical Society's PRO Advocacy Committee will meet February 16 at 4 p.m. at IMS headquarters. Topics to be discussed include IFMC Board elections and the IFMC study group process. (See story on the bylaw changes in this month's **Medical Economics.**)

IMS election process continues

Delegates to the 1994 IMS Nominating Committee are being chosen at district caucuses held across Iowa. The Nominating Committee will meet March 6 by telephone to assemble the candidate slate for the 1994 elections. The election will take place on Sunday, April 17 during the IMS House of Delegates meeting.

Offices to be filled include president, vice-president, trustee, House of Delegates speaker and vice-speaker, three AMA delegates and one AMA alternate delegate.

Focus on IMS Alliance

Health system reform was the focus at the IMS Alliance board meeting in late January. Paul von Ebers, senior vice president for Blue Cross Blue Shield, spoke regarding possible legislative action this year. Sandy McCool, AMAA field director, spoke on national health care legislation.

March 1 is the deadine for nominations for the Alliance Member of the Year award. Send your nominations to Sandy Nichols at IMS headquarters. The award will be presented at the 1994 Annual Meeting.

Contributed by Judy Hoenk, IMSA president

Interesting topics at Scientific Session

Gene therapy, problems in the elderly and a discussion of primary care initiatives at the University of Iowa will highlight the 1994 IMS Scientific Session. The session will be held April 15-17 in conjunction with the IMS House of Delegates meeting.

A full day of scientific programs is planned for Friday, April 15 at the Hotel Savery. The emphasis will be on issues pertinent to women, children and the elderly. These will include hypertension and confusion in the elderly, heart disease and infertility in women, childhood immunizations, evaluation of the febrile child and hyperactivity in children.

John Colloton, vice president for Statewide Health Services at the University of Iowa, will be guest speaker at a joint IMS/IMS Alliance luncheon on Friday.

On Saturday, MMIC will hold a special risk management program. The Scientific Session will conclude on Sunday morning with a presentation by Roger Tracy, director of Community Based Programs at the UI College of Medicine. He will discuss the University's primary care initiatives.

On Sunday morning, there will also be a presentation by Kenneth Culver, MD, director of human gene therapy research at Iowa Methodist Medical Center in Des Moines.

The program has been approved for 10 hours in Category 1 of the AMA Physicians' Recognition Award. Watch the March *Iowa Medicine* for a detailed Scientific Session program and registration information.

You are encouraged to reserve your hotel room in advance with the Savery Hotel by calling 515/244-2151. IM

The emphasis will be on issues pertinent to women, children and the elderly.

Health System Reform

AT A GLANCE

The Democratic National Committee is considering showing an interactive video promoting the Clinton health plan at 60 to 80 shopping malls around the country.

The Iowa Medical Society will hold a special Open Forum on Health System Reform in conjunction with its annual House of Delegates meeting. The Forum will be held at 10:30 a.m. Saturday, April 16 at the Savery Hotel, Des Moines and is open to any interested physician. Watch next month's Iowa Medicine *for further details.*

The IMS ad hoc committee charged with studying the feasibility of an Independent Practice Association (IPA) will meet this month to make a recommendation to the IMS Board of Trustees regarding hiring of a consultant.

Legislature considering IHRC plan

Iowa Health Reform Council (IHRC) recommendations on reforming Iowa's health care delivery system are being debated by the Iowa Legislature. The recommendations were presented to the Legislature by Governor Terry Branstad.

The IHRC plan includes a requirement that businesses offer (but not pay for) standard group insurance coverage, a standard benefits package, pricing insurance according to community ratings and tax credits for doctors who agree to practice in rural Iowa. The group also proposes tort reforms including caps on noneconomic damages and a shortened statute of limitations for minors.

Dr. John Anderson, IMS president, said the Council's proposals "represent progress toward reform which benefits Iowans" and urged Iowa physicians to contact their legislators to express support.

However, some legislators have been predicting there will be only "minor surgery" on the state's health care delivery system due to bickering between parties and party members brought on by the 1994 gubernatorial race.

For more information about the IHRC proposals now under consideration, see the special final issue of the **IMS Member Report** sent to all IMS members in mid-January.

AMA policy change on employer mandate

In the wake of its mid-December policy change regarding employer insurance mandates, the American Medical Association continues to reiterate its "unalterable support" for universal insurance coverage for all Americans.

The AMA House of Delegates took action to expand the range of options for achieving universal coverage to include both employer and employee funding. Several national groups including the American Academy of Family Physicians and the American Academy of Pediatrics continue to support employer mandates as the only way to achieve universal coverage and openly criticized the AMA action.

Lonnie Bristow, MD, AMA board chair, said the AMA is "sensitive to the needs of small businesses" and is "amenable to different proposals" as long as they achieve universal access.

In an explanatory statement, AMA officials said the policy change "offers a more balanced nonpartisan approach that keeps paramount the best interests of patients while at the same time addressing the need for cost containment. We believe this improves the prospects that meaningful reform will occur before Congress adjourns late in 1994."

The AMA sent a letter to President Clinton clarifying the policy change. Prior to the meeting at which the policy change was approved, AMA officials expressed disappointment over the fact the White House did not plan to send a high-ranking official to the meeting.

Meanwhile, a poll of the nation's governors showed they support President Clinton's goal of providing health insurance to everyone but are split on whether employers should have to pick up the tab.

IMS reviewing employer mandate policy

In light of AMA actions, Iowa Medical Society leadership is reassessing IMS policy regarding employer mandates for health insurance coverage.

IMS policy includes a long-standing endorsement of AMA policy calling for employer mandates as the way to achieve universal coverage. Following the policy review, IMS legislative staff will update the IMS position paper on this issue.

Who's an employee?

President Clinton's health plan would require businesses to help pay for employees'

health coverage but the plan does not define who is to be considered an employee.

How employees would be distinguished from free-lance workers or independent contractors could have a significant impact on the cost of the Clinton plan.

Rather than propose definitions, the President is asking Congress to let the U.S. Treasury Department write regulations addressing the issue after the health care bill has been approved. However, critics argue that Congress must address the issue since it will be impossible to assess the financial impact of a regulation that hasn't been written.

Use of independent contractors is widespread and this issue could reach far beyond health care because the way businesses classify workers helps determine their own tax obligations.

Physician opinion on Clinton plan

In a poll conducted in late 1993, 83% of physicians supported the Clinton health system reform plan on features that would extend coverage and access to Americans. These include no denial or loss of coverage for any reason, a comprehensive benefit package, limits on the growth of health insurance premiums and liability reforms requiring alternative forms of dispute resolution.

On other aspects of the Administration's plan, physicians were more critical, reports the AMA. Areas of opposition include cuts in Medicare and Medicaid (81%), creation of a National Health Board (56%) and allocation of residency training positions by the government (62%). Seventy-one percent of physicians polled said the Clinton plan does not go far enough on liability reform because it does not include a cap on non-economic damages.

An AMA official said the poll demonstrates more work needs to be done on the Clinton plan but that "physicians are ready to work with the Administration and Congress toward a health system reform plan that puts patients first."

The poll was taken among AMA members and non-members.

Special issue on health system reform

In mid-January, all IMS members should have received the final issue of the IMS Member Report, which was dedicated to health system reform. Members are advised to keep this newsletter for future reference.

If you have misplaced your copy or did not receive one, call Bev Corron at IMS, 515/223-1401 or 800/747-3070 for another copy.

Whatever did he mean?

Though Ross Perot suffered a resounding defeat on NAFTA, he may be taking aim at a new target — the Clintons' health system reform proposal. The *New York Times* says Mr. Perot has begun criticizing the plan's "soft financial side".

Perot called the President's proposed health alliances a "giant government bureaucracy". This bureaucracy, he added mysteriously, "will make the Pentagon look like a bunch of ballet dancers". IM

Seventy-one percent of physicians polled said the Clinton plan does not go far enough on liability reform.

Worth Repeating

Carroll Campbell, Jr., governor of South Carolina, had this to say about health system reform:

"It's my belief that any plan that inserts government between people and their doctors will be a loser, not a winner."

Legislative Affairs

AT A GLANCE

Don't miss this month's insightful feature article on the Community Health Management Information System (CHMIS) which could be approved by this year's Iowa Legislature.

Paul Bishop is the Iowa Medical Society's new staff legislative liaison. He represents the IMS at the Iowa Legislature, coordinates IMPAC and is responsible for grassroots political activities.

Friday, March 4 is the first "funnel deadline" in the 1994 Iowa Legislature, the last day for House bills to be reported out of House committees and Senate bills out of Senate committees.

IMS position papers available

The IMS public affairs department has position papers on a number of key health care issues and is making them available to member physicians.

The position papers discuss the IMS policy on issues including health system reform, CHMIS, the state fiber optic network, medical liability reform, prescribing by nurse anesthetists and others.

For copies of these position papers, call Lyn Durante at the IMS, 515/223-1401 or 800/747-3070.

Faster legislative communications

The Iowa Medical Society has implemented a fax broadcast system to aid communications during this year's Iowa legislative session.

The fax broadcast system allows the IMS to send a brief message to all IMS Legislative Contact Persons simultaneously. Alliance members who coordinate the IMS Phone Bank will now be responsible for notifying LCPs that an important fax asking physicians to contact legislators is on its way and should be acted on immediately.

The fax message will contain the necessary details about the issue and the action requested.

Motorcycle groups seek repeal

Federal provisions which encourage states to adopt seat belt and motorcycle helmet use laws are under attack in Congress this year, according to a communique from the American College of Emergency Physicians (ACEP).

Section 153 of the Intermodal Surface Transportation Efficiency Act of 1991 requires states to enact both seat belt and motorcycle helmet use laws or face diversion of federal highway funds into safety programs in states not complying. The provisions take effect October 1, 1994.

More than 110 House members have co-sponsored repeal legislation. In the Senate, two bills have been introduced. Opponents of the provisions — especially of the helmet law requirement — are increasing their pressure on Congress through calls and letters to congressional offices.

The ACEP is urging its members to contact their congressmen in support of the Section 153 provisions.

The Iowa Medical Society is supporting helmet law legislation in the 1994 Iowa Legislature. The IMS supported similar legislation in 1993, but the bill underwent significant alteration and was vetoed by Governor Branstad because it would not have prevented diversion of federal highway funds.

Gubernatorial primary race

This June's gubernatorial primary has been in the news since Republican U.S. Congressman Fred Grandy announced his intention to challenge incumbent Governor Terry Branstad.

The Iowa Campaign Finance Law makes it illegal for political action committees to con-

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50309

You may also contact your legislator at home when the Legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, contact Lyn Durante of the IMS staff.

For more information about any legislative issue, call Becky Roorda of the IMS staff.

IMS telephone numbers are 515/223-1401 or 800/747-3070.

ribute to candidates in Iowa elections while he Iowa Legislature is in session.

Following adjournment of the Iowa Legislature, the Iowa Medical Policical Action Committee (IMPAC) Board of Directors will evaluate the status of the race.

Medicine and politics . . . 1994

IMPAC is gearing up for a watershed year in Iowa politics. IMPAC helps ensure physicians' voices are heard. Iowa lawmakers have begun considering health system reform. It is imperative the concerns of Iowa physicians and their patients be represented.

An IMPAC membership campaign is underway. Unfortunately, contributions are down from a year ago. In 1992, IMPAC was outspent by lawyer groups. Jackson Ver Steeg, MD, IMPAC Board chairman, urges Iowa physicians to consider IMPAC membership.

Following are members of the IMPAC Board of Directors, listed by congressional districts, who ensure your contributions go to pro-medicine candidates:

CHAIR — Jackson Ver Steeg, MD
VICE CHAIR — William Eversmann, MD
TREASURER — Jane Winston, MD
CHAIR, LEGISLATIVE COMMITTEE — Kevin Cunningham, MD

FIRST DISTRICT: Amir Arbisser, MD and John O'Shea, MD. **SECOND DISTRICT**: Leah Willson, MD and Ed O'Neil, MD. **THIRD DISTRICT**: Donald Berg, MD and John Shierholz, MD. **FOURTH DISTRICT**: Michael Egger, MD and Lynn Struck, MD. **FIFTH DISTRICT:** Gene Herbek, MD and Carey Bligard, MD

Willing Provider legislation

Who will be allowed to participate in the health care delivery system is the issue underlying "any willing provider" legislation being discussed around the country.

As a result of the activities of the Iowa Health Reform Council and changes already occurring in Iowa's health care delivery system, that issue is also being discussed here.

Willing provider laws can take many forms, ranging from legislation that requires due process for physicians applying to a health care plan or network to legislation that requires health care plans to take all providers willing to accept the plan's level of payment.

Some proposals are not limited to physicians and hospitals and may serve as vehicles for mandating payment for services by nonphysician practitioners.

In Iowa, introduction of broad-based legislation is expected as health system reform discussions continue. Many provider groups are concerned about being left out of accountable health plans or other established delivery systems. The IMS is concerned about the form this legislation may take and will monitor it closely.

The AMA addressed this issue at its interim meeting in December, 1993:

- AMA reaffirms its policy supporting changes in antitrust laws to allow physicians and physician organizations to engage in group negotiations with managed care plans.
- Physicians have the right to apply to any health care plan or network in which they desire to participate and to have that application approved if it meets physician-developed criteria available to applicants and enrollees. The criteria should be based primarily on professional competence and quality of care.
- Managed care organizations and third-party payers should be required to disclose to physicians the criteria used to select, retain or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution and specialties of physicians needed.
- That health care plans or networks using criteria to determine the necessary number, geographic distribution and specialties of physicians be required to report regularly to the public the impact such criteria has on the quality, access and cost of health care provided to patients. IM

Some proposals may serve as vehicles for mandating payment for services by nonphysician practitioners.

Health Care will be Priority in Iowa Legislature

Health care will be a priority of the 1994 state legislative session, according to both House and Senate leaders. They have voiced general agreement on the need to lay groundwork to ensure basic health care coverage for all Iowans while waiting for action at the federal level. The report of the Health Care Reform Council (HCRC) is likely to be the starting point for discussion.

However, expect disagreements on the exact approach to take. Senator Elaine Szymoniak, chair of the Senate Human Resources Committee, indicated discussion of the Council's report will be a priority for her committee.

Governor Branstad has also made health system reform a priority for 1994 and recommended in his Condition of the State message to the Legislature that they enact the HCRC recommendations.

Medical Economics

Medicare payment request sent

The Iowa Medical Society has once again sent a formal request to the Health Care Financing Administration (HCFA) asking that Iowa be designated a single Medicare payment locality. IMS leadership believes the move will increase the possibility that physicians will be attracted to rural areas.

However, it is uncertain how HCFA will respond to the new request.

A similar request from IMS was denied in 1992 due to opposition from the University of Iowa, the Iowa Osteopathic Medical Association (IOMA) and the Polk County Medical Society (PCMS). They opposed the single Medicare payment locality because of potential reimbursement reductions.

However, in 1993, the University of Iowa College of Medicine Faculty Practice Plan notified IMS that it now supports efforts toward a single locality and the 1993 IMS House of Delegates directed staff to repetition HCFA.

At HCFA's direction, members of PCMS and IOMA were surveyed during the past two months to reassess support for the proposal.

Polk County sent out 700 letters asking members to vote on the proposal. A total of 305 physicians responded, with 180 voting against the single Medicare payment locality and 125 expressing approval. IOMA sent 280 letters. Ninety-seven physicians responded, with 51 voting yes and 46 voting no.

A HCFA official told IMS staff that numerous states have applied for single payment locality status during the past few months.

New ruling on vaccine tax

The IMS has received new information regarding the one-day vaccine tax imposed under the Omnibus Budget Reconciliation Act of 1993. The one-day tax, implemented on vaccines in stock on August 10, 1993, applies to any provider holding a taxable vaccine for sale or use ***on August 10 only.***

However, any provider holding vaccines subject to a total tax of $1,000 or less is not required to report or pay the tax. If the tax on vaccines in stock August 10 exceeds $1,000, the full amount of tax must be reported and paid on form 720 by February 28, 1994.

If you have further questions, call Donna Bottorff at IMS, 515/223-1401 or 800/747-3070.

IFMC seeks bylaws changes

Following is a bulleted summary, written by the Iowa Foundation for Medical Care (IFMC), of proposed bylaws changes. The changes are divided into **Resolution A** and **Resolution B**.

Resolution A concerns physician membership, member voting procedures and some Board of Directors requirements.

Resolution A also covers how the Board will handle future revision of IFMC Articles and Bylaws, proposing that bylaw changes be approved by a 2/3 vote of the IFMC Board rather than a full member vote. **Resolution B** concerns nonphysician directors or IFMC committees.

According to the IFMC, language has been clarified without changing its intent as items are moved. New items are also proposed for addition.

Resolution A . . . (IFMC language)

- Bylaws may be amended upon 2/3 vote of Directors. Any such amendments would be submitted to full member vote upon receipt of petition signed by 10% of members. *(Current provision requires member vote on any change.)*
- IFMC membership requirements are stated. *(Moved to Articles, no substantive change.)*
- IFMC members must register once every three years. *(New.)*
- IFMC member vote is required on any proposed change in company ownership. *(New.)*
- IFMC member votes are to be conducted by mail. *(Current provision allows some balloting at meetings.)*
- Proxy voting is prohibited. *(Moved to Articles, no substantive change.)*
- At least 75% of directors are to be IFMC physician members elected by IFMC physician

AT A GLANCE

Need help on CPT Coding? The AMA staff provide assistance by phone at 312/464-4737 or by fax at 312/464-5762.

Copies of the December 2, 1993 FEDERAL REGISTER are available for $4.50 from the Government Printing Office. Specify Stock #069-001-00063-7 by phone 202/783-3238 or fax 202/512-2250, with a credit card.

*Effective January 20, physicians should be adding the **name of the referring physician** in addition to the physician's UPIN number on Medicare B claims.*

Ballots for election of IFMC Board of Director positions were mailed in early January. Results of the election are expected to be announced this month.

members. [The number of directors is fixed in Bylaws.] *(New.)*

- Director tenure is restricted. *(Moved to Articles, no substantive change.)*
- President must be IFMC member and Iowa resident. *(New.)*
- Provisions for amending Articles defined. *(Moved to Articles, no substantive change.)*

Resolution B . . . (IFMC language)

- IFMC Board is to determine what groups are to be represented by nonphysician directors. *(Current provision spells out which specific groups, i.e. nursing home administrators, are to be represented on the IFMC Board.)*
- Majority of non-physician directors are to be residents of Iowa. *(Current provision requires all nonphysician directors to be Iowa residents.)*
- Minimum size of Comprehensive Review Committee is to be five members. *(Current provision sets size at 10 members.)*
- Minimum size of Long Term Care Committee is to be five members. *(Current provision sets size at 10 members.)*
- At least 60% of Long Term Care Committee members are to be physicians. *(Current provision requires all members of this committee to be physicians.)*
- District Peer Review Committees references deleted. *(These committees have not existed for many years, making references obsolete.)*

As of press time, IFMC planned to mail ballots in late January with complete language of the proposed bylaw revisions, a summary of the revisions and voting procedures. IFMC officials said members will be able to vote separately for Resolution A and Resolution B.

BCBSI customary fee adjustment

The Blue Cross and Blue Shield Physician Advisory Committee approved a two-phase approach for the customary fee update for services provided July 1, 1993 through June 1, 1994. The first phase was implemented last July and resulted in substantial increases for cognitive services. The amount of increases varied by specialty and typically ranged from 5-10% for services in the Evaluation/Management category.

Phase Two applies to services provided on or after January 1, 1994. BCBSI will implement new customary payment amounts for surgical services identified as significantly overvalued in relationship to procedures of similar complexity. The new Usual, Customary and Reasonable (UCR) payment rates were developed using a combination of historic customary rates and an analysis of relative values.

According to BCBSI, the majority of physician specialties will see minimal, if any, financial impact as a result of this adjustment. The overall impact this adjustment has will depend on factors including frequency and the physician's charge for specific procedures.

BCBSI says it will work with representatives of affected specialties to ensure the work and other overhead factors used to establish customary fee limitations are correct.

BCBSI says the majority of physicians will see little, if any, financial impact as a result of this adjustment.

Data on practice costs sought

The IMS Data Acquisition and Analysis Committee continue research into types of data the IMS will need to remain a viable advocate for physicians. The committee is exploring two areas: data on physician practice costs (bad debt, charity care, regulatory and liability costs); and acquisition of data such as that collected by Medicare, Medicaid and other sources.

At a recent meeting, the committee discussed avenues through which physicians can gain access to necessary data, and agreed that the Medical Group Management Association is a source worth further investigation.

The committee considers the small area analysis studies developed through the IMS Utilization Assessment Subcommittee an important method of involving physicians in the study of usage rates in Iowa.

IPA committee to meet

The Iowa Medical Society's Ad Hoc Committee on the Feasibility of Creating an Independent Practice Associationwill meet February 9 at the IMS. The IMS House of Delegates has directed the IMS to "consider the feasibility of establishing a statewide IPA which would negotiate a fee schedule with third parties subject to compliance with antitrust laws."

The purpose of the February 9 meeting is to assist the Board in determining whether a consultant is needed to assist with a formal feasibility study. Factors to be considered include the current practice environment in Iowa, existing IPAs and the legal, political and cost implications for IMS members.

The committee will be asked to make a recommendation to the Board of Trustees. IM

Members, IMS Committee on the Feasibility of Creating an IPA

John Rhodes, Jr., MD
Wilson Davis, Jr., MD
John Fernandez, MD
Mark Liaboe, MD
Merle Muller, MD
Gene Parks, MD
Louis Rodgers, MD
James Stiles, MD
Michael Welton, MD

Practice Management

AT A GLANCE

The Iowa Medical Group Management Association (IMGMA) will print job advertisements free orf charge in its quarterly newsletter. Any physician searching for an office manager or other personnel should contact Kathleen Ziemer, IMGMA staff, at 515/223-2816 or 800/728-5398.

Elaine Raines, director of human resources at McFarland Clinic, Ames, says questions which lead a job candidate to describe his or her previous situation are often the best predictors of how the person will handle similar situations. For example, ask, "What is the worst work-related problem you have encountered? Tell me how you dealt with it."

Data bank information release

The IMS has been advised that, in recent months, various insurance organizations have required as part of their application process that physicians submit a copy of their physician "self-inquiry" information from the National Practitioner Data Bank.

Third party payers currently do not have legal access to Data Bank information.

The American Medical Association is seeking legislation that will make it illegal to require a practitioner to submit a copy of a file report from the Data Bank to any agency not authorized to have access to the data bank by the Health Care Quality Improvement Act.

In the meantime, the AMA has developed a letter which can be used by physicians when seeking acceptance on third party payer, select provider panels.

The letter has protective language in it that prohibits the third party payer from using the information for other than the reasons listed.

Copies of this letter are available for any Iowa physician. Call Donna Bottorff at IMS headquarters, 515/223-1401 or 800/747-3070.

Please watch future issues of *Iowa Medicine* for more information on the AMA's efforts.

IMS Medline offers advantages

The IMS Medline long distance telephone program has been in existence for two years and offers physicians the chance to take advantage of group buying power while retaining the service level of an individual customer. The program uses US Sprint's 100% digital fiber optic network.

Where most long distance carriers bill in one-minute increments, IMS Medline users are billed in one-tenth of a minute increments. Portability is available which allows an office to keep its current 800 number when switching long distance service to IMS Medline. A calling card is also available. The per call access charge using the card is 25 cents.

IMS Medline long distance service is available to physicians and staff for residential phones as well as offices and clinics. For applications or a free analysis of your current telephone statements compared to IMS Medline rates, call Sandy Nelson at IMS Services, 515/223-2816 or 800/728-5398.

IMGMA salary survey

The Iowa Medical Group Management Association, with the assistance of McGladrey and Pullen, is conducting a biannual salary survey of physician office employees.

The results of the salary survey will be distributed this spring to IMGMA members at no charge. Nonmembers can purchase the survey for $75. For more information, call Mark Templeton at IMS Services, 515/223-2816 or 800/728-5398.

Upcoming Workshops for You and Your Practice

CPT Coding	**Tuesday, March 1**	**Sioux City**
ICD9 Coding	**Wednesday, March 2**	**Sioux City**
Valuing Your Practice	**Wednesday, March 9**	**Iowa Methodist Medical Center, Des Moines**

Watch your mail for program brochures or call Sherry Johnson at the IMS for details.

IMS staff will be happy to schedule individual speaking engagements on 1994 CPT Coding changes and Year Three of Physician Payment Reform. IMS also has a program for practice management assessments for physician offices or clinics across Iowa. For more information, call Barb Cannon at the IMS, 515/223-1401 or 800/747-3070.

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- **Use a cover page**
- **Include a confidentiality statement**
- **Maintain a log of faxed information**
- **Verify receipt of the transmission**
- **Follow with a hard copy within 24 hours**

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Employee integrity tests

There was a time when the validity of employee integrity tests was questioned, but the tests have begun to gain more credibility.

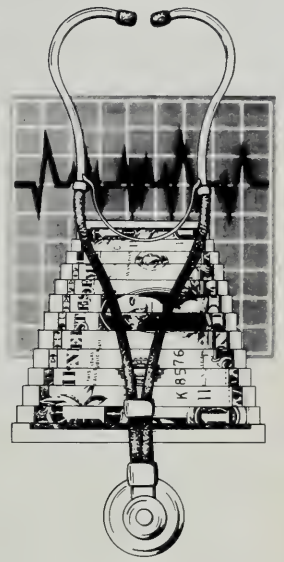
A study at the University of Iowa indicates they may be valid in determining a potential employee's honesty and may even help employers predict overall job performance.

The study results showed integrity tests were accurate predicters of negative behavior such as violence, drinking, destruction of equipment, excessive absenteeism, theft and overall job performance.

The UI study examined results of pre-employment tests given to about 500,000 blue and white collar workers, and researchers concluded that honesty may be the best predictor of conscientiousness, which in turn predicts job performance.

There are over 40 employee integrity tests on the market, but none is better than the others, say researchers.

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Practice Management

continued

Latest on sexual harassment cases

Editor's note: This article was written by Frank Harty of the Nyemaster law firm in Des Moines.

Sexual harassment continues to pose a significant problem in the workplace. In a recent ruling, the U.S. Supreme Court sent a strong message to employers that they must rid the workplace of all forms of sexual harassment.

Well over 100 sexual harassment claims are filed each year in Iowa. A recent U.S. Supreme Court ruling should spur every employer to take steps to avoid this risk.

The court ruled that psychological harm is not a necessary element in a sexual harassment action.

In Harris v. Forklift Systems, Inc., the court held that plaintiffs in sexual harassment cases need not show they suffered severe emotional distress as a result of the harassment. The trial court had concluded that Forklift's president had directed sexual innuendo but that there was no abusive or hostile environment. The Court of Appeals affirmed the trial court decision but the Supreme Court reversed the ruling, saying that psychological harm is not a necessary element in a harassment action.

There are two main types of sexual harassment recognized by the courts: (1) situations in which a subordinate employee is forced to submit to a supervisor's sexual advances to retain a job or advance; and (2) a sexually hostile work environment in which sexually explicit remarks, sexual jokes and sexual advances are so common that the workplace becomes intolerable for reasonable persons.

Victims of sexual harassment can sue their employers for lost wages, emotional damages and other forms of compensatory damages, punitive damages and attorney fees. The potential liability for employers is substantial.

Preventing Sexual Harassment Suits in Your Office

To minimize risk of a sexual harassment suit in your office or clinic, take these steps:

- Adopt and disseminate a policy strictly prohibiting sexual harassment of any nature.
- Your policy should define both types of sexual harassment mentioned above.
- The policy should outline a complaint procedure allowing an alleged victim to report harassment to someone other than his or her direct supervisor if necessary.
- The policy should assure victims that there will be no retaliation if a complaint is made.
- Train employees to recognize and avoid potential problem situations.

MMIC's favorable rates

Iowa physicians not currently insured by Midwest Medical Insurance Company are responding well to MMIC's new lower rates. Late in 1993, MMIC announced a 1994 rate reduction of 8% to 13% for all policyholders.

If your office would like a premium estimate, call Tom Leners at IMS headquarters, 515/223-2816 or 800/728-5398.

The January issue of *Iowa Medicine* contained a special insert on the advantages offered by MMIC. The insert included a tear-out card to obtain further information.

Medical business specialist program

For the first time, the IMS is offering a Medical Business Specialist certification to physician office staff. The program will provide certification for staff which signifies completion of a core curriculum in business operations of a medical office.

Successful candidates must complete 10 program modules which vary from three to eight hours in length. To request more information, call Barb Cannon at the Iowa Medical Society, 515/223-1401 or 800/747-3070.

Do you send overnight packages?

Through IMS Services, IMS members will soon have access to an overnight delivery program from Airborne Express which offers considerable advantages.

IMS members will get fixed domestic and international rates which are up to 40% below competitive rates.

Our member rate for an 8 oz. letter will be $9.25 (next morning delivery of an overnight express letter) or $8.00 for 3 p.m. delivery.

Members who average five or more shipments a day will get rates of $7.50 (next morning delivery) and $6.50 (3 p.m. delivery).

All shipments are discounted regardless of weight and members will receive free customized shipping packets.

For more information, call Sandy Nelson at IMS Services, 515/223-2816 or 800/728-5398.

SPHP completes actuarial study

The IMS has received results of an actuarial study completed on insurance offered to physician employees and families through the Statewide Physicians Health Program.

The study, completed by Carl Harris and Associates, was conducted to ascertain whether or not the IMS was paying the proper premiums for benefits provided.

The actuary concluded the IMS group has been and is paying a rate appropriate for the underlying benefits. IMS loss ratio for the past several years has been 88%, meaning that benefits of $88 were returned for each $100 of premium collected. Of the remaining $12, all but $2 to $3 was spent on expenses and related items.

The actuary concluded that this is not the appropriate time to take the risk of forming an IMS insurance entity.

Please correct your 1994 CPT book

The word "expanded" belongs in the key components of both the history and examination for E & M codes 99202, 99212, 99242, 99252, 99272, 99282, 99283, 99322 and 99342.

The following changes should also be made:

- Code 93017 — Cardiovascular stress test—tracing only should be added to your book.
- In the index, the Hernia Repair, Laparoscopic and Laparoscopic Hernia Repair codes should be 56316 and 56317.
- Under Cesarean Delivery, the parenthetical note to " . . . see 99150, 99151" should read (For Standby Attendance for Infant, see 99360).
- Codes 99358 or 99359 "Prolonged Physician Service without Direct Patient Contact" should be used to report time spent reviewing Workers' Compensation cases. See your 1994 CPT book for further information. IM

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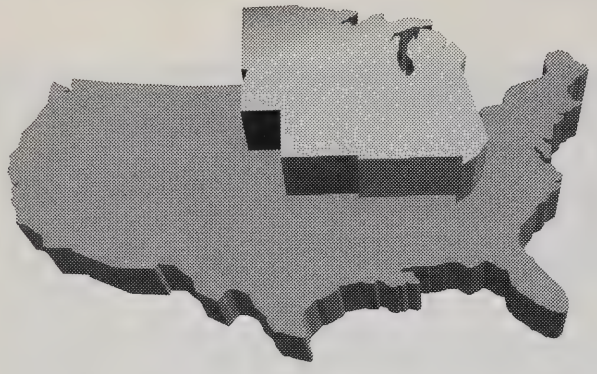
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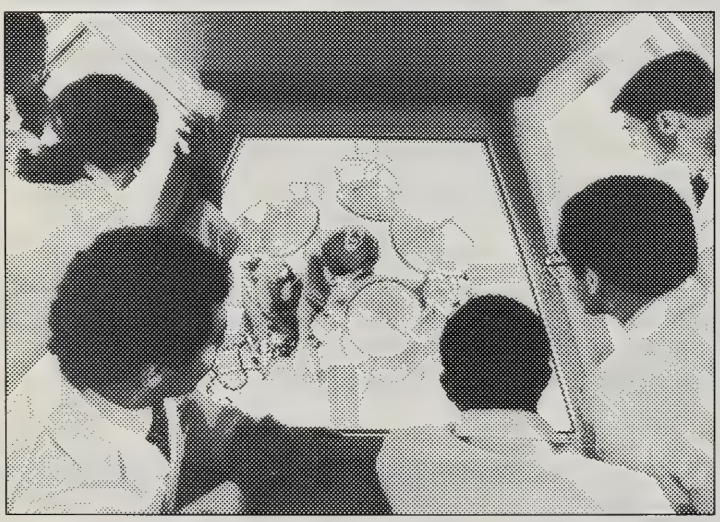
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Newsmakers

Praise and criticism of *Iowa Medicine*

Dear Dr. Alberts:

Thank you for the thoughtful editorial in the December issue of *Iowa Medicine* ("Are you truly educated?). I am sending a copy to each of our children. It stimulated me to look through my files and come up with an item you might value. I hope you enjoy the enclosed.

Please extend my best regards to all my old friends at the IMS.—*Paul Kersten, MD, Nokomis, Florida.*

Letter to the Editor

Dear Editor:

When the personal news and obituary material was elimnated from the Journal, I think it was a great disservice to everyone and particulaly retired members.

Hopefully, this can be reinstated.—*Dean Cooper, MD, Punta Gorda, Florida.*

Editor's note: Last year, because of space constraints, the monthly "About IMS Members" column was reduced to four times a year. Starting with the January 1994 issue, this **Newsmakers** section will again be published monthly. Letters to the editor, awards, appointments, etc. may be sent to Editor, *Iowa Medicine,* 1001 Grand Avenue, West Des Moines, Iowa 50265.

Recognition for Iowa physician

Dear Editor:

I thought you would appreciate hearing about a newsworthy item that definitely speaks well for Dr. Cham Kongtahworn from Des Moines. Dr. Kongtahworn was recently a guest of Dr. Dudley Johnson's in Milwaukee, Wisconsin. As you know, Dr. Johnson is a world reknown heart surgeon and Dr. Kongtahworn was asked to come to Milwaukee to discuss the results of his pioneering work with the Maze procedure. The Maze procedure is a cutting edge technology procedure designed to help patients with atrial fibrillation who need restoration of sinus rhythm and have failed all other therapeutic modalities.

Dr. Kongtahworn's new approach to the problem involves incorporating the Maze procedure with other surgical procedures which are performed on a more routine basis (like coronary artery bypass grafting, valve surgery, etc.). Dr. Kongtahworn has had tremendous sucess and was well received when he came to Milwaukee. As a result of his visit, the Maze procedure is now being performed in Milwaukee.

Please contact me if you wish to know any further details. I can be reached at 3201 South 16th Street, Suite 1015, Milwaukee, Wisconsin 53215-4532; phone 414/645-6070.—*Galen Van Wyhe, MD, Milwaukee, Wisconsin.*

Awards, appointments, etc.

Dr. Albert Clemens, longtime surgeon, retired after 36 years of practice at Mercy Hospital Medical Center, Des Moines. **Dr. David Hussey,** UI Hospitals and Clinics, Iowa City, was named treasurer for a third term of the American Society for Therapeutic Radiology and Oncology. **Dr. Jeffrey Krivit,** Cedar Rapids, received the American Academy of Otolaryngology/Head and Neck Surgery Continuing Medical Education Achievement Award at the academy's annual meeting in Minneapolis. **Dr. Steven Wahle** was inducted into the American College of Surgeons at a meeting in San Francisco, California.

Deceased members

Ralph Edwards, MD, 87, life member, general practice, Centerville, died November 22

John Ferguson, MD, 75, life member, family practice, Newton, died December 16

AT A GLANCE

Penny Jeffery, *a third-year medical student at the University of Iowa College of Medicine, received one of 10 national $50,000 scholarships from the Nicholas J. Pisacano, MD Memorial Foundation. The scholarships are awarded to students who make a commitment to family practice.*

David Marker *has been appointed president of the University of Osteopathic Medicine and Health Sciences in Des Moines. Mr. Marker has been president at Cornell College in Mount Vernon since 1984.*

Newsmakers

continued

New members (as of September 1993)

Algona
Alan Scher, MD, general surgery

Altoona
Deborah Haines, DO, general practice

Ames
Aeneid Chen, MD, obstetrics/gynecology

Ankeny
Sara Schutte-Duistermars, DO, pediatrics

Cedar Rapids
John Alcini, Jr., MD, radiology
Todd Gothard, MD, ophthalmology
Deborah Janicki, MD, general practice
Greg Hayes, MD, resident
Colleen Keating, MD, resident

Charles City
Kevin Kimm, DO, family practice

Chariton
Kenneth Anderson, DO, internal medicine

Clinton
Miquel Alcordo, MD, internal medicine
Divyang Joshi, MD, internal medicine

Clive
Bashar Kayali, MD, pediatrics
Claude Koons, MD, obstetrics/gynecology

Council Bluffs
George Cheeseman III, MD, family practice
Bradley Kusler, MD, general surgery

Davenport
John Broman, MD, family practice
Bradley DeWall, MD, general surgery
Darryl Johnson, DO, general surgery
John Klosak, MD, vascular surgery
Richard Leth, MD, anesthesiology
Enrico Melson, MD, family practice
Todd Roehr, MD, anesthesiology
Valeries Bonnett, MD, resident
Dolores Lowe, MD, resident
Min Su Pak, MD, resident
Randy Sevcik, MD, resident
Mureema Solberg, MD, resident
Tammy Jo Wells, MD, resident

Des Moines
Joseph Bender, DO, psychiatry
Ricardo Bendezu, MD, resident
Frederick Black, DO, resident
Kimberly Blakeslee, DO, family practice
Roger Blanchard, Jr., MD, resident
Catherine Brosius, DO, resident
Harry Candoleon, DO, resident
Ben Collins, DO, internal medicine
Susan Donahue, DO, resident
William Gammon, MD, resident
Joseph Gilg, MD, rheumatology/internal medicine
Devon Goetz, MD, hip/knee and joint
Vybert Greene, MD, obstetrics/gynecology
Jerome Greenfield, MD, psychiatry
Surinder Grewal, MD, resident
Katrina Guest, MD, internal medicine
David Harrison, DO, resident
Marvin Huff, DO, resident
Siva Jagarlapudi, MD, internal medicine
Lee Johannsen, MD, resident
Paul Johnson, MD, anesthesiology
Tawny Johnston, DO, resident
Lisa Kock, DO, resident
Gregory Matlock, MD, resident
Jerry McCauley, DO, resident
Kimberly Price, DO, resident
Dawn Schissel, MD, family practice
Debbie Schueller, MD, resident
Michael St. Pierre, MD, resident
Sara Baker Scott, DO, family practice
Sherry Shrestha, MD, family practice
Joel Stenzel, MD, pediatrics
Kennen Thompson, MD, resident
Valerie Torgerson, DO, resident
Mark Uhl, MD, gastroenterology
Carey Wimer, DO, internal medicine
Jon Winjum, MD, resident
Tom Woodard, DO, general practice

Dubuque
Thomas Benda, Jr., MD, otolaryngology/head & neck surgery
Timothy Berger, MD, internal medicine
Randall Busch, MD, anesthesiology
David Field, MD, orthopaedic surgery
John Hartmann, DO, family practice
Laura Hemann, MD, radiology
Yasyn Lee, MD, psychiatry
Timothy Walsh, MD, anesthesiology

Fairfield
Winn Gregory, MD, general surgery

Forest City
Pamela Keller, MD, family practice

Fort Dodge
Grace Ang, MD, internal medicine
Charles Race, MD, orthopedics

Indianola
Duane Caylor, MD, family practice

For information on joining the IMS, call the IMS Membership Department, 800/747-3070 or 223-1401.

Here's to your Health
A patient guide to better health
Provided by the Iowa Medical Society

Low back pain

Oh, my aching back!

More people see doctors for back pain than for any other medical ailment except colds and upper respiratory problems. Many of the six million Americans who see a doctor each year because of back pain did not use proper methods of lifting and moving an object.

Back pain is common among laborers, warehouse workers and caregivers. Studies show nurses rank second only to heavy construction workers in the number of persons suffering back pain.

Most back pain lasts only a few days, but one of six persons has experienced severe back pain that lasts at least two weeks. The cost of treatment, lost wages and rehabilitation of back pain sufferers is unknown but is believed to be enormous.The direct costs of medical bills paid by insurance and payment for lost wages from low back pain are estimated at $11.5 billion per year.

Who is at risk?

You are at risk for back pain if:

- your job requires frequent bending and lifting
- you must twist your body when lifting and carrying objects
- you must lift and carry in a hurry
- you are overweight
- you do not exercise regularly or do not engage in recreational activities
- you smoke

What causes low back pain?

Many things can cause low back pain — muscle strain or spasm, sprains of ligaments (which attach

Insert to *Iowa Medicine*, February 1994

bone), joint problems or a "slipped disc". The most common cause of low back pain is using your back muscles in activities you're not used to, such as lifting heavy furniture, playing basketball or doing yard work.

A slipped disc happens when the disc between the bones bulges and presses on nerves. This is often caused by a twisting movement while lifting. But many people won't know what caused it.

Back pain can also follow normal activities, such as bending over the sink to brush your teeth. Back pain may be made worse by stress, long periods of inactivity or being in an unusual position for a long period.

What should I do when I've hurt my lower back?







The best position for relief when your back hurts is to lie on your back on the floor with pillows under your knees, with your knees bent and your feet on a chair, or just with your knees bent (see diagram at left). This takes the pressure and weight off of your back.

If you have injured your back, you may need several days of this sort of rest. Resting longer than this can cause your muscles to weaken, which can slow your recovery.

Even if your back hurts, walk around for a few minutes every hour. If you're resting a tired back, stay in one of these positions for five to 25 minutes at a time.

Heating pads can help to relax painful muscle spasms. Use heat for 20 to 30 minutes at a time.

Ice packs and massages may also give relief. Medicines that reduce pain and swelling include aspirin, ibuprofen (Advil, Medipren, Motrin, Nuprin) and acetaminophen (Datril, Excedrin, Panadol, Tylenol).

Is there relief for ongoing back problems?

Treatment of ongoing back problems must be directed at the cause. This may mean losing weight (being overweight can make back pain worse), getting your muscles in better shape through exercise and improving your posture when you're standing, sitting and sleeping.

Most people feel much better within a few weeks. Serious problems are rare.

Tips for preventing back strain

◆ Separate your feet shoulder-width apart to give you a solid base of support.

◆ Don't lift by bending over. Lift an object by bending your hips and knees and then squatting to pick up the object. Keep your back straight and hold the object close to your body.

◆ Avoid twisting your body while lifting. Instead, point your toes in the direction you want to move and pivot in that direction.

◆ Don't try to lift an object that is too heavy. Get help!

◆ Push rather than pull when you must move heavy objects.

◆ If you must sit at your desk or at the wheel of the car for long hours, break up the time with stops to stretch.

◆ Think about your posture.

◆ Wear flat shoes or shoes with low heels (one inch or less).

Right way to lift



Wrong way to lift



What's the best position for standing?

If you must stand for long periods, rest one foot on a low stool to relieve pressure on your lower back. Every five to 15 minutes, switch the foot you are resting on the stool. Move around as much as you can. Maintain good posture — keep your ears, shoulders and hips in a straight line, your head up and your stomach pulled in.

What's the best way to sit?

Sitting puts more pressure on your back than any other position, even more than standing. To reduce this pressure, sit in chairs with straight backs or low-back support. Keep your knees a little higher than your hips. Adjust the seat or use a low stool to prop your feet.

Turn by moving your whole body rather than by twisting at your waist. Use a swivel chair to help reduce twisting.

When driving, sit forward and move the seat forward. This helps you not lean forward to reach the controls. You may want to put a small pillow or rolled towel behind your lower back if you must drive or sit for long periods.

Call your family doctor if...

- **Pain goes down your leg below your knee.**
- **Your leg, foot, groin or rectal area feels numb.**
- **You have fever, nausea or vomiting, stomachache, weakness or sweating.**
- **You lose control over going to the bathroom.**
- **Your pain was caused by an injury.**

Exercises to strengthen your muscles

1. Wall slides to strengthen your back, hip and leg muscles



Stand with your back against a wall and feet shoulder-width apart. Slide down into a crouch with knees bent to about 90 degrees. Count to five and slide back up the wall. Repeat five times.

2. Leg raises to strengthen back and hip muscles



Lie on your stomach. Tighten the muscles in one leg and raise it from the floor. Hold your leg up for a count of 10 and return it to the floor. Do the same with the other leg. Repeat five times with each leg.

What's the best position for sleeping?

The best way to sleep to reduce the pressure on your back is on your side with your knees bent. You may put a pillow under your head to support your neck. You may also put a pillow between your knees.

If you sleep on your back, put pillows under your knees and a small pillow under your lower back. Don't sleep on your stomach unless you put a pillow under your hips.

Use a firm mattress. If your mattress is too soft, use a board of 1/2 inch plywood under the mattress to add support.

What exercises can I do to strengthen my back?

You can minimize back pain problems with exercises that make muscles in your back, stomach, hips and thighs strong and flexible. Some people keep in good physical condition through activities such as running, walking, bike riding and swimming.

The diagrams at left show several specific exercises which can help your back.

Before beginning any exercise program, you should discuss the program with your doctor and follow the doctor's advice.

This information on low back pain has been compiled from publications of the American Academy of Family Physicians and the American Academy of Orthopaedic Surgeons. As a service to Iowa Medical Society member physicians, this insert may be photocopied for placement in clinic reception areas. Original inserts may be purchased from the Iowa Medical Society. Call Chris Clark, director of communications, at 515/223-1401 or 800/747-3070.

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Ronald Rossing, MD, aviation medicine

Windsor Heights
Sharon Means, MD, pediatrics IM

IMS Annual Scientific Session and House of Delegates will be held at the Savery Hotel in Des Moines April 15-17.

CHMIS ...a *MiXeD MeSSage* for PHYSICIANS

Chances are good the Iowa Legislature will enact a Community Health Management Information System (CHMIS) during this session. Will CHMIS be ultimately beneficial for Iowa patients and physicians or will it be a grand and expensive failure? The answer depends on many factors.

Implementation of the Community Health Management Information System (CHMIS) should be viewed by Iowa physicians with cautious optimism.

CHMIS has the potential to reduce health care delivery costs, reduce the "hassle factor" in dealing with third party payers and improve the quality and efficiency of health care.

Unfortunately, it also has the potential to increase health care costs and produce inaccurate and unreliable information which may damage both patients and physicians.

Finally, the Iowa Medical Society believes CHMIS could pose significant risks to the confidentiality of patient medical records and has voiced concern over this potential use of the system.

Paperless claims, insurance verification

Creation of a statewide electronic network to transmit insurance claims and establishment of a uniform claims format will be the simplest, least expensive and most welcome of the CHMIS proposals. Physicians will be able to verify rapidly their patients' insurance eligibility and coverage levels. Transmission of paperless claims will be easier, less expensive and quicker than processing the paper claims we know (and dislike) today. Payment may be rapidly credited to our accounts electronically and accounts receivable may be significantly reduced.

Physicians will be able to verify rapidly their patients' insurance eligibility.

Offices will need a computer

Costs for this part of the CHMIS proposals should be minimal. Offices which are already computerized will need only to acquire the necessary software.

Noncomputerized offices will need a basic computer, monitor, printer and modem, all of which are available at local electronics stores. Software cost should be insignificant.

Unless we are burdened with unjustly high access charges for the system, it should be inexpensive, efficient and physician friendly.

Creating a central repository which will collect, analyze and disseminate information from patient records will be difficult and expensive.

If this part of the system can be made to work, it will place at our fingertips a complete and accurate history of our patient's diagnoses, treatments, laboratory tests and drug utilization. The concept is exciting. Unfortunately, major potential prob-

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Dr. Briggs practices obstetrics/gynecology in Marshalltown. He is chairman of the Iowa Medical Society Ad Hoc Committee on CHMIS.

lems must be addressed and solutions found before the central repository should be implemented.

Cost difficult to estimate

The cost of establishing and maintaining such a central repository is difficult, if not impossible, to estimate. Start up costs will be high — both for complex hardware and for software which is, at this time, unproven. Unless small pilot projects establish the effectiveness and reliability of the software, numerous and expensive modifications — if not complete revisions — may be necessary.

Who will be asked to pay for this system? The taxpayers of Iowa? The insurance companies? Physicians and hospitals? Data entry costs have the potential to skyrocket as the governance board requires more and more complex information to be filed with each entry. Filing costs may exceed compensation for brief patient encounters.

Physicians may hesitate

Verification of the accuracy and completeness of the information in the central depository must be assured.

We all know how easy it is to enter incorrect information into a computer system. Physicians may be hesitant to enter more sensitive patient information making files incomplete or inaccurate. As a result of these and other factors, we may not be able to rely on information in the system in treating our patients.

Also, it is possible the system will assign patients with incorrect diagnoses, and these diagnoses could haunt them for years.



The central repository is intended to provide purchasers of health care with information related to cost, utilization and quality of care of providers. Accurate data on physician practice patterns and charges should be easily obtained, but what about indicators of quality?

As proposed, patient satisfaction studies and functional status surveys will serve as the basis for determining quality. Poor or even incompetent providers with good bedside manners treating hypochondriacs may be rated highly, while the most competent physician treating very sick patients may be judged poorly.

Iowa physicians must be certain that conclusions based on this data are accurate and reliable.

Confidentiality of individual patient medical records must be guaranteed.

Confidentiality must be guaranteed

Confidentiality of patient medical records must be guaranteed. Only providers who need such information to treat patients should have access to records (with the patient's consent). All others, including purchasers, employers, governmental agencies and researchers must have access only to aggregate information. If

patient confidentiality cannot be guaranteed absolutely, the entire concept of a central repository should be scrapped.

In summary, CHMIS has the exciting potential for increasing the quality and decreasing the cost of medical care. However, there are also many potentially serious pitfalls which could stand in the way of its success.

Before the state of Iowa mandates the statewide implementation of CHMIS, this system must be proven cost effective, workable, accurate and, most important, confidential in small pilot projects.

If these safeguards are not followed, CHMIS may become a grand and expensive failure in the history of health care in Iowa. IM

FEATURE SIDEBAR

Demand for data gave birth to CHMIS

There is widespread public demand for data on the cost and quality of health care in Iowa. In 1993, the Iowa General Assembly directed a steering committee to develop recommendations to create an electronic data interchange system for health care information.

This data interchange system is now commonly referred to as the Community Health Management Information System (CHMIS).

Reducing administrative costs

CHMIS — generally accepted as the information component of health system reform in Iowa — is expected to help reduce administrative costs through uniform electronic transfer of health care information while maintaining patient confidentiality.

On December 13 of 1993, the CHMIS Steering Committee adopted its final report to the Iowa General Assembly. It is widely believed legislation will be enacted in 1994 to create a CHMIS. However, the system which is finally approved could be considerably different from that recommended by the steering committee.

It is widely believed legislation will be enacted in 1994 to create a CHMIS.

All claims submitted electronically

Under CHMIS, all claims would be submitted electronically using an American national Standards Institute format. Physicians would have the choice to either submit claims directly to the payer or through a network that will automatically direct the claim to the correct payer.

Remittance and patient eligibility information would be transmitted in this same manner. When there are capitated payments, encounter information would be transferred through the system. Encounter information includes diagnosis and procedure codes, but does not include charges.

Third-party payers, which would include health insurance companies, health maintenance organizations and self-insured plans, would also be required to use the uniform bill-

Timothy Gibson
Tim Gibson is vice president of policy and programs for the Iowa Medical Society and has had extensive staff involvement with the Iowa Health Care Reform Council.

ing format. In addition, insurers would be required to participate in networks to assure that claims for other companies would be forwarded for processing if a physician wishes to submit billing information to only one insurer.

It is anticipated these requirements will become effective July 1, 1996. In the future, additional information such as laboratory tests, x-ray results, inpatient pharmacy codes and aggregate data sets indicating clinical performance would also be transferred through the electronic network. This would not occur until July 1, 1999.



Ultimately, clinical record information may be transferred utilizing the system. However, the steering committee has recommended additional legislation be required in subsequent years to use the network for this purpose.

Data repository

In addition to being an electronic network for transferring claims encounter and remittance information, CHMIS will have a data repository. Certain information will be transferred from the system in to a data repository to collect cost and utilization information. It is anticipated the data will be adjusted for severity.

Information on quality will likely be drawn from clinical data sets and provided to the repository separately. It is also anticipated that patient satisfaction information will be collected and submitted to the repository.

Governed by nonprofit group

CHMIS advocates believe these various data sets can be merged, providing meaningful information to the public.

The CHMIS Steering Committee has recommended the CHMIS be governed by a non-profit private organization. To assure public accountability, the governing board would be appointed by the governor and subject to confirmation by the Iowa Senate.

The governing board would consist of two physicians, two hospital representatives, two insurer representatives, two employment-based purchasers and four consumers. It would develop business policies for the CHMIS and its users and these policies would be enforced through the Insurance Division.

In addition, the governing board would have a public policy responsibility to determine what data is to be collected.

Once the CHMIS becomes fully operational, it is anticipated the Iowa Health Data Commission (IHDC) would cease to exist and its responsibilities transferred to the CHMIS. IM

Ultimately, clinical record information may be transferred utilizing the system.

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Course Objectives and Intended Audience

This course is designed to provide family practitioners, internists, other primary care physicians and nurses with practical approaches to common cardiovascular disorders. The course will emphasize diagnostic evaluation, treatment modalities and day-to-day management of these disorders from the perspective of the primary care physician.

Registration Fees:

Physicians	$50.00
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(includes course materials, breakfast, lunch and refreshments)

Registration Deadline is March 18, 1994.

Registration is limited. For registration information, please contact Paulette Bailey or Shawn Klocke (319) 364-7101.

Program

7:30	Registration
8:00	Opening remarks
8:15	New ideas on an old arrhythmia - Atrial Fibrillation
9:00	Syncope
9:45	BREAK
10:00	Coronary revascularization using arterial conduits
10:45	Cardiac evaluation of the parient undergoing non-cardiac surgery
11:30	Question session
12:00	Lunch
1:00	Current therapy for carotid artery disease; Medical and surgical approaches
2:00	Questions
2:15	BREAK

Concurrent Workshops

2:30	Auscultation of the heart - media presentation Pediatric Cardiology GUSTO
3:15	BREAK
3:30	Auscultation of the heart - media presentation Management of common arrhythmias Medical case studies
4:15	Evaluations

The Journal
of the Iowa Medical Society

Update on local anesthetics

● ROBERT FORBES, MD; DAVID MURRAY, MD

Local anesthetics can be administered effectively in a variety of ways. This article reviews clinical uses of local anesthetics and adverse reactions. EMLA Cream, a newer preparation for topical anesthesia, is discussed.

Clinical uses of local anesthetics

Local anesthetics consist of lipophilic and hydrophilic portions joined by a hydrocarbon chain. The lipophilic end, essential for anesthetic activity, is generally an unsaturated aromatic ring, such as para-aminobenzoic acid. It is joined to the hydrocarbon chain by an ester (-CO-) or amide (-NHC-) link and it is this bond that is used to classify these drugs as ester or amide local anesthetics. The basic clinical differences between these two types of local anesthetics are related to their metabolism and their potential for producing allergic reactions (Table 1).

Local anesthetics are used most frequently to produce regional anesthesia that can be classified according to the site of drug placement, such as topical anesthesia, local infiltration, peripheral nerve block or intravenous block (Table 2, following page).

Topical anesthesia

Local anesthetics produce surface anesthesia when placed on the mucous membrane of the eye, the upper airway and tracheobronchial tree, or the genitourinary tract. Lidocaine, cocaine and tetracaine are most commonly used for this purpose. Cocaine has the additional advantage of also causing vasoconstriction. Rapid systemic absorption of local anesthetic occurs with mucosal application. This rapid absorption is not altered by the use of epinephrine so care must be taken to avoid toxic reactions.

Many transdermal or topical anesthetic preparations have been marketed over the past 35 years but none have provided consistently effective, safe dermal anesthesia because of their poor penetration through normal skin. This occurs because topical local anesthetic

TABLE 1
COMMON LOCAL ANESTHETICS

Esters		
Procaine (Novocain)	1%	10 mg.ml
	2%	20 mg.ml
Toxic dose (adult)* 500 mg		
Chloroprocaine (Nesacaine)	2%	20 mg.ml
	3%	30 mg.ml
Toxic dose (adult)* 800 mg		
Tetracaine (Pontocaine)	0.5%	5 mg.ml
	1.0%	10 mg.ml
Toxic dose (adult)* 150 mg		
Cocaine	2%	20 mg.ml
	5%	50 mg.ml
	10%	100 mg.ml
		150 mg.
Toxic dose (adult)† 150 mg		
Amides		
Lidocaine (Xylocaine)	0.5%	5 mg.ml
	1.0%	10 mg.ml
	2.0%	20 mg.ml
Toxic dose (adult)† 500 mg		
Bupivacaine (Marcaine)	0.25%	2.5 mg.ml
	0.50%	5.0 mg.ml
Toxic dose (adult) 200 mg		

**Toxicity: Assumes healthy (70 kg) adult, no concurrent disease or medication.*
†Cocaine Toxicity: Myocardial ischemia due to coronary spasm may occur in susceptible individuals at much lower dose.

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for February 1994.

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Dr. Forbes and Dr. Murray are associate professors in the University of Iowa College of Medicine Department of Anesthesia, Iowa City.

Update on local anesthetics

continued

preparations that use crystal forms of the drug must be dissolved in oil before being incorporated into an emulsion. Therefore, they cannot provide adequate concentrations of the base form of the local anesthetic.[1,2]

EMLA Cream (Eutectic Mixture of Local Anesthetics) is a topical anesthetic emulsion containing lidocaine 2.5% and prilocaine 2.5%. By formulating these medications in an eutectic mixture, the melting points of both drugs are decreased and they exist as liquids at room temperature. This greatly increases the concentration of the local anesthetics and absorption and penetration through the skin is greatly enhanced.

To provide analgesia for a minor procedure, such as placing an intravenous catheter, a thick layer (1-2 Gm over 10-20 cm^2) of EMLA cream should be applied at 1 or 2 potential sites then covered by an occlusive dressing for at least an hour.[3,4] For more painful procedures a longer application time may be necessary. Analgesia is maximal after 2 to 3 hours of application and will persist for up to 2 hours after the EMLA is removed.[5]

The plasma levels are well below toxic plasma concentrations, if the maximum recommended application area is not exceeded.[6] Larger treatment areas, prolonged application time and impaired metabolism or excretion of local anesthetics due to hepatic or renal dysfunction may result in higher blood concentrations, particularly in smaller patients. Also, if EMLA cream is used along with other local anesthetics, the cumulative effects of all the agents could produce toxic blood levels.

TABLE 2
REGIONAL BLOCKADE USING LOCAL ANESTHETICS

Topical	Mucous membrane
	Skin
	Laceration
Infiltration	Subcutaneous
Peripheral nerve block	Digital
	Intercostal
	Radial
	Median
Field block	Scalp
(multiple peripheral nerve blocks)	Ankle
	Wrist
	Inguinal
Plexus or ganglion block	Brachial plexus
	Celiac plexus
	Stellate ganglion
Intravenous regional	Upper extremity
(Bier block)	Lower extremity
Conduction (CNS site)	Epidural caudal
	lumbar
	thoracic
	Spinal (subaracnoid)

Few adverse reactions

Few adverse reactions have been noted following the use of EMLA cream. Pallor, erythema and mild edema have been noted in the area of application but these effects are transient.[1,7] Allergic and anaphylactoid reactions are potential problems. Methemoglobinemia can occur following the administration of large doses of prilocaine. This reaction is spontaneously reversible or the methemoglobinemia can be corrected using intravenous methylene blue.[8]

Absorption of lidocaine and prilocaine in EMLA cream is greatly increased when it is applied to mucous membranes and safe dosing guidelines for its use in these areas are not yet available. Also, EMLA cream can be ototoxic if it penetrates the tympanic membrane and enters the middle ear.[9]

EMLA cream provides safe, effective analgesia for a wide variety of procedures including venipuncture, IV or arterial cannulation, lumbar puncture and bone marrow biopsy, harvesting of skin grafts or surgical treatment of other minor skin problems.[1,4,6,7,10,11] It appears to be less effective in children under 7 years of age probably due to their fear of needles.

TAC (tetracaine, adrenaline and cocaine) is a potent anesthetic solution that has been used to produce topical anesthesia for laceration repair, particularly in children.[12] The solution contains high concentrations of epinephrine (1:2,000) and cocaine 11% combined with a moderate concentration of tetracaine 0.5%. Tetracaine probably contributes little to the local anesthetic effect of this combination.[13]

Eleven percent cocaine (110 mg/ml) carries significant risks. A toxic dose producing seizures in an adult is 200 mg (<2 ml of an 11% solution), but even smaller doses of cocaine (<50 mg) can produce an intense systemic vasoconstrictive effect.[14,15] In sus-

ceptible individuals, coronary artery spasm leading to myocardial ischemia or infarction and lethal ventricular arrhythmias have been observed with larger doses (a "line" of intranasal cocaine is estimated at less than 100 mg).[15,16] While significant systemic cocaine absorption from small lacerations is unlikely, inadvertent application of TAC to mucous membranes or on large lacerations where more systemic absorption is possible is a potentially lethal complication, particularly in children.[17] Topical application tends to inappropriately lessen concern about the toxicity of this extremely potent solution. The intense vasoconstrictive effect of the cocaine and epinephrine contraindicates the use of TAC in end-artery locations (*e.g.* digits, pinna of the ear, penis). The addition of epinephrine to cocaine does not improve vasoconstriction or decrease cocaine absorption but does increase the risk of toxicity.[18,19] Deaths associated with "cocaine mud," a preparation of cocaine and epinephrine, led to the proscription of this preparation.[18] As expected, similar episodes have occurred with tetracaine, adrenaline and cocaine and this preparation should also be eliminated from clinical use, particularly in children.[17]

Local infiltration

Local anesthesia for minor surgical procedures can be achieved by simple extravascular infiltration of a dilute anesthetic solution into the surgical site to produce blockade of the subcutaneous sensory nerves. If a large volume of anesthetic solution is needed, the maximum recommended dose should not be exceeded.

Epinephrine added to local anesthetic solutions serves several purposes. The vasoconstrictive effect of epinephrine delays the systemic absorption of local anesthetic lowering the peak plasma concentration and reducing the potential for local anesthetic toxicity.[14] A longer duration of anesthesia also results from the delayed absorption. The vasoconstriction produced by the epinephrine decreases bleeding and in this way may improve the quality of wound closure. Epinephrine is contraindicated in tissues supplied by end arteries, such as fingers, toes or ears, because vasoconstriction in response to the epinephrine may result in tissue ischemia or necrosis. Also, epinephrine is rapidly absorbed through mucous membranes and for this reason should not be included in preparations applied to these areas.

The combination of lidocaine and epinephrine reduces the potential systemic toxicity of both drugs. Lidocaine and epinephrine are frequently administered together even when the goal is only to decrease bleeding from an operative site. Epinephrine does not produce similar benefits when combined with other local anesthetics. The toxicity of cocaine, which blocks the reuptake and degradation of catecholamines, actually increases when epinephrine is added. For this reason, cocaine and epinephrine should not be administered together.

The addition of epinephrine carries other risks. The reduction in blood flow to the wound site could contribute to infections by impairing macrophage and neutrophil entry to the site in the early stages of wound repair. Systemic absorption of epinephrine is also a significant concern because the tachycardia and hypertension produced by epinephrine may actually increase bleeding. Epinephrine is particularly helpful for producing vasoconstrictive effects in highly vascular tissues, such as the scalp or face, but it is in these situations that there is also more rapid absorption and a greater risk of intravascular injection.

Tachycardia and hypertension can be detected even with small (10-15 μg) intravenous doses of epinephrine (Table 3). A dose of 100 μg in a healthy adult would result

Few adverse reactions have been noted following the use of EMLA cream.

TABLE 3
EPINEPHRINE CONCENTRATIONS*

1:1,000	1000μg/ml (1mg.ml)
1:10,000	100μg/ml
1:50,000	20μg/ml
1:100,000	10μg/ml
1:200,000	5μg/ml

**Systemic effects in adults from intravenous administration:*

(a) 10μg IV — Heart rate and blood pressure increase 10-20%

(b) 100μg IV — Tachycardia >120bpm, systolic hypertension >140mmHg, diastolic hypertension >90mmHG

(c) 1,000μg (1 mg) IV — Supraventricular or ventricular arrhythmias, premature ventricular contractions, malignant hypertension

Update on local anesthetics

continued

in a profound tachycardia and hypertension. Palpitations, sweating, headache, flushing and nausea or vomiting are all common, unpleasant symptoms that follow the systemic absorption of 50-100 μg of epinephrine and are much more common than are allergic or anaphylactic reactions to local anesthetics.

A 1:200,000 solution of epinephrine is the most common preparation available in local anesthetics. One percent lidocaine with epinephrine contains 10 mg of lidocaine and 5 μg of epinephrine per ml. Local anesthetics with higher concentrations of epinephrine must be prepared by local pharmacies due to the short half-life of the epinephrine. The lack of any proven benefit of high concentrations of epinephrine and the greater risk of side effects should encourage physicians to abandon use of these concentrated epinephrine solutions.

Peripheral nerve block

Regional anesthesia can also be achieved by injection of an anesthetic agent into close proximity of a specific peripheral nerve or nerve plexus. Blockade of autonomic and motor nerves may accompany the sensory block.[20-22] The duration of action is affected by the dose administered, the lipid solubility and protein binding of the specific agent used and the presence of epinephrine in the solution. Administration of bupivacaine with epinephrine 1:200,000 can produce a sensory nerve block lasting up to 24 hours.

Intravenous block

Injection of an anesthetic solution into the venous system of a limb isolated from the systemic circulation by a tourniquet can produce rapid, profound anesthesia and muscle paralysis.[23] This is a simple, effective method of producing regional anesthesia for operations involving the hand and forearm. Anesthesia recedes following release of the tourniquet and there is a risk of a toxic local anesthesia reaction if the tourniquet is released prematurely. Deflation of the tourniquet should be avoided for at least 15 minutes following initial injection of the drug.[24]

Lidocaine and prilocaine are the local anesthetics most commonly used to produce intravenous anesthesia. Bupivacaine for regional anesthesia has been associated with profound cardiovascular depression and intractable dysrhythmias.[25] Therefore, the use of bupivacaine for intravenous blocks is contraindicated.

Adverse effects

Adverse effects are generally due to allergic reactions or systemic toxicity. Allergic reactions to local anesthetics are rare and the majority of adverse reactions that occur are, in fact, attributable to systemic toxicity resulting from high plasma concentrations of the drug.

Allergic reactions — Allergic reactions are frequently related to the metabolites of the ester-type local anesthetics. Manifestations of an allergic reaction include rash, urticaria, laryngeal edema, bronchospasm and hypotension.[26,27] Allergic reactions may also be due to the presence of preservatives, such as methylparaben, commonly found in commercial local anesthetic preparations. Cross-sensitivity can occur between different ester local anesthetics but not between ester and amide-type anesthetics, if the solutions used are preservative free.

Systemic toxicity — Systemic toxicity due to local anesthetics occurs when excessive plasma concentrations of the drug are produced, most commonly following inadvertent intravascular injection of a local anesthetic. Excessive plasma concentrations can also occur following rapid absorption from an extravascular injection site.

The central nervous system is very sensitive to the effects of local anesthetics.[28] Signs and symptoms of CNS toxicity include numbness of the lips, lightheadedness and vertigo. This may be followed by visual disturbances and tinnitus and the patient may become disoriented or drowsy. Signs of CNS excitation may also occur including slurred speech, shivering, and muscle twitches of the face and extremities. This can progress rapidly to generalized tonic-clonic convulsions. When a very large dose of local anesthetic is administered, initial CNS excitation may be followed by central nervous system depression, hypotension, and apnea. Emergency treatment of seizures due to local anesthetic toxicity includes securing the airway, administration of oxygen, and assisting ventilation, if

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necessary. Thiopental or diazepam are effective for controlling the seizures.

The cardiovascular system is more resistant than the central nervous system to the toxic effects of local anesthetics. With higher plasma concentrations, pacemaker activity in the sino-atrial node is depressed, causing sinus bradycardia or sinus arrest. Similar depression of the atrioventricular node may result in partial or complete AV dissociation.[29]

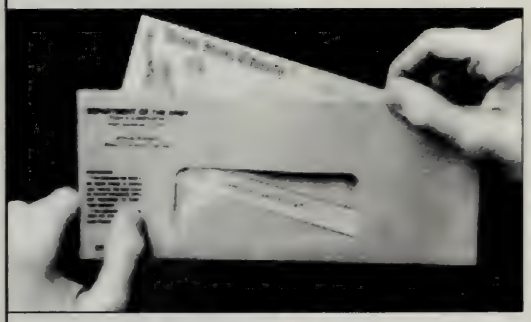
Local anesthetics in toxic concentrations are also negative inotropes. The more potent, highly lipid-soluble agents, such as bupivacaine, tend to be the most cardiotoxic and severe cardiac depression and dysrhythmias following inadvertent intravascular injection have been reported.[25,30] Although lidocaine has a similar action on cardiac cells the effect is transient. In addition, all local anesthetics, except cocaine, cause peripheral vasodilation, which may exacerbate the hypotension caused by myocardial depression. Overall, the incidence of adverse reactions to local anesthetics is extremely low if these agents are administered appropriately.

References

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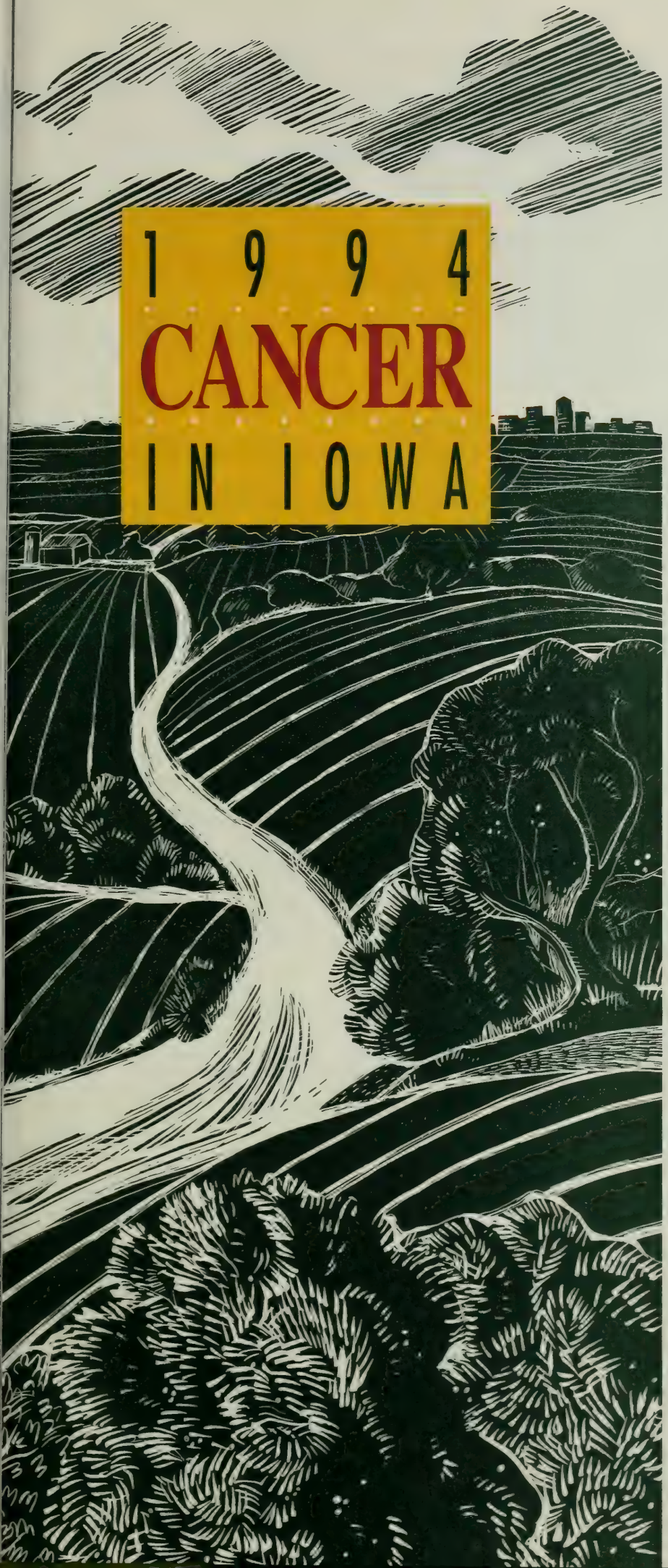
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FACTS ABOUT **CANCER** IN IOWA

During 1994, Iowans will develop 14,500 new cancers

Five out of six cancers occur in Iowans 55 and older

Lung cancer causes one in four cancer deaths

Prostate cancer will comprise almost one-third of all new cancers in men

Breast cancer will comprise 30 percent of all new cancers in women

In 1994, an estimated 6,500 Iowans will die from cancer, 13 times the number caused by auto fatalities. These projections are based on data from the State Health Registry of Iowa. The registry has been recording the occurrence of cancer in Iowa since 1973.

As one of ten registries in the country funded by the National Cancer Institute (NCI), Iowa represents the rural and Midwestern populations and provides data found in many NCI publications.

Produced by
STATE HEALTH REGISTRY OF IOWA
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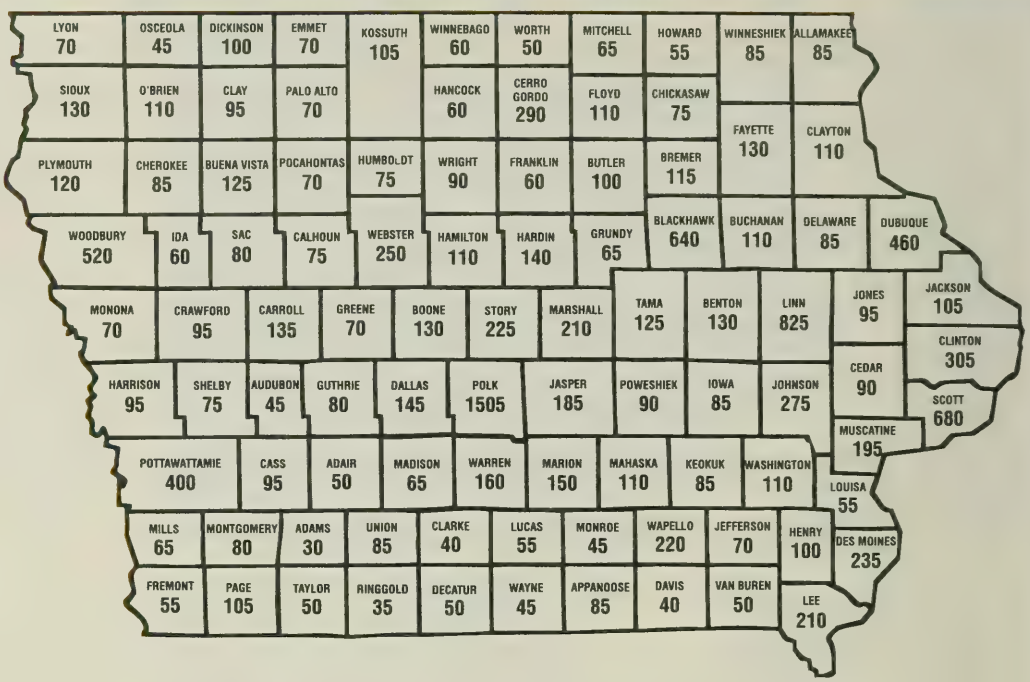
The State Health Registry of Iowa is located at The University of Iowa in the College of Medicine's Department of Preventive Medicine and Environmental Health. The staff includes more than 50 people. Half of them, situated throughout the state, regularly visit hospitals, clinics, and medical laboratories in Iowa and neighboring states. In 1994, data will be collected on 14,500 new cancers among Iowa residents. A follow-up program tracks more than 97 percent of the 260,000 Iowans diagnosed with cancer since 1973. This program provides regular updates to keep the data current and useful.

This excerpt provides information from the State Health Registry's annual publication *Cancer in Iowa*.

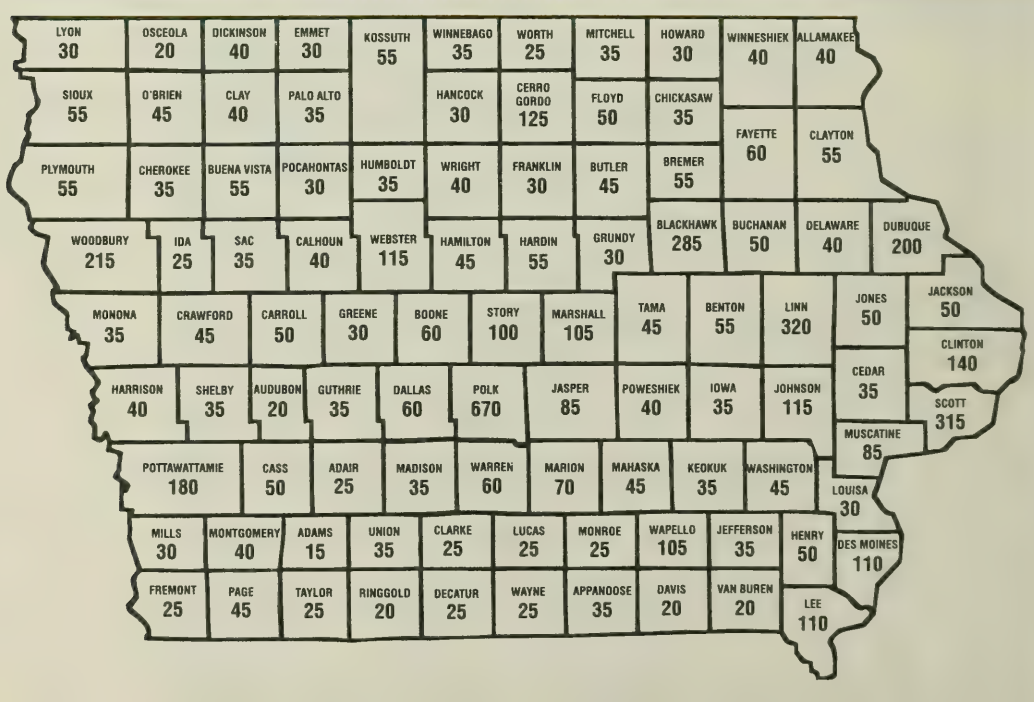
CANCER PROJECTIONS FOR 1994

Cancer affects Iowans of all ages and in every county. In 1994, cancer will strike five out of every 1,000 and bring death to two of them.

ESTIMATED NUMBER OF NEW CANCERS IN IOWA FOR 1994



ESTIMATED NUMBER OF CANCER DEATHS IN IOWA FOR 1994



TOP 10 TYPES OF CANCER IN IOWA ESTIMATED FOR 1994

Among women, breast cancer is the most common and, along with colon, rectum, and lung cancers, will account for more than half the new cases. The increase in smoking among women over the past few decades has placed lung cancer as the leading cause of cancer deaths.

New Cancer in Females

SITE	# OF CASES	% OF TOTAL
BREAST	2100	30.0
COLON & RECTUM	1075	15.4
LUNG	790	11.3
UTERUS	405	5.8
OVARY	310	4.4
NON-HODGKIN'S LYMPH.	280	4.0
SKIN MELANOMA	185	2.6
LEUKEMIA	180	2.5
PANCREAS	165	2.3
KIDNEY & RENAL PELVIS	145	2.2
ALL OTHERS	1365	19.5
TOTAL	7000	

Cancer Deaths in Females

SITE	# OF CASES	% OF TOTAL
LUNG	600	19.5
BREAST	595	19.3
COLON & RECTUM	395	12.8
OVARY	180	5.9
PANCREAS	160	5.2
NON-HODGKIN'S LYMPH.	140	4.6
LEUKEMIA	125	4.1
BRAIN	75	2.4
KIDNEY & RENAL PELVIS	70	2.3
MULTIPLE MYELOMA	60	2.0
ALL OTHERS	675	21.9
TOTAL	3075	

Prostate, lung, colon, and rectum cancers account for over 60 percent of new cases among males. Lung cancer causes almost one-third of all cancer deaths in men.

New Cancer in Males

SITE	# OF CASES	% OF TOTAL
PROSTATE	2400	32.0
LUNG	1300	17.3
COLON & RECTUM	990	13.2
NON-HODGKIN'S LYMPH.	275	3.7
BLADDER	250	3.3
LEUKEMIA	225	3.0
KIDNEY & RENAL PELVIS	190	2.5
SKIN MELANOMA	190	2.5
ORAL CAVITY	165	2.2
PANCREAS	150	2.0
ALL OTHERS	1365	18.3
TOTAL	7500	

Cancer Deaths in Males

SITE	# OF CASES	% OF TOTAL
LUNG	1090	31.8
PROSTATE	460	13.4
COLON & RECTUM	385	11.2
NON-HODGKIN'S LYMPH.	160	4.7
PANCREAS	150	4.4
LEUKEMIA	135	3.9
BLADDER	100	2.9
BRAIN	90	2.6
KIDNEY & RENAL PELVIS	90	2.6
ESOPHAGUS	85	2.5
ALL OTHERS	680	20.0
TOTAL	3425	

Cancer remains the second most common cause of death. Over the past 25 years, deaths from heart disease have markedly decreased while cancer has continued a steady increase. If these trends continue, cancer will become the leading cause of death early in the next century.

TOP 10 CAUSES OF DEATH IN IOWA ESTIMATED FOR 1994

CAUSE	NO.	PERCENT
HEART DISEASE	9045	32.9
CANCER	6500	23.6
CEREBROVASCULAR DISEASE	2085	7.6
PNEUMONIA	1210	4.4
CHRONIC OBSTRUCTIVE & PULMONARY	1150	4.2
ACCIDENTS	1075	3.9
DIABETES	610	2.2
ARTERIOSCLEROSIS	465	1.7
OTHER ARTERIAL DISEASES	360	1.3
INFECTIONS	330	1.2
ALL OTHER CAUSES	4670	17.0

Cancer occurs in people of all ages, although more than 80 percent of the cases occur in those 55 and older. Among children, leukemia and brain cancer are most common, while lung, colon, rectum, breast, and prostate cancers occur with greatest frequency among older Iowans.

TOP 3 TYPES OF NEW CANCER IN IOWA ESTIMATED FOR 1994: Females & Males by Age Group

	SITE	# OF CASES
Ages 75+	BREAST	640
	COLON & RECTUM	560
	LUNG	195
	PROSTATE	1075
	LUNG	400
	COLON & RECTUM	375
Ages 55-74	BREAST	900
	COLON & RECTUM	445
	LUNG	400
	PROSTATE	1315
	LUNG	780
	COLON & RECTUM	510
Ages 35-54	BREAST	475
	LUNG	75
	COLON & RECTUM	70
	LUNG	105
	COLON & RECTUM	75
	SKIN MELANOMA	55
Ages 15-34	BREAST	40
	THYROID	30
	SKIN MELANOMA	30
	TESTIS	40
	HODGKIN'S DISEASE	25
	SKIN MELANOMA	20
Ages Under 15	LEUKEMIA	15
	BRAIN	10
	SOFT TISSUE	5
	LEUKEMIA	15
	BRAIN	10
	NON-HODGKIN'S LYMPH.	5

Fortunately for Iowans, the chances of being diagnosed with many types of cancer can be reduced through positive health practices such as smoking cessation and healthful dietary habits. Early detection through self-examination and regular health check-ups can dramatically improve cancer treatment and survival. During the 1990s, preventive measures and early detection should show positive changes in the cancer statistics reported by the registry.

Necessary controls or pointless meddling?

Few of us would deny that controls in various segments of our society are necessary. The Constitution of the United States provides Americans certain freedoms; but not the freedom of doing anything we desire.

Some controls are dictated by social customs and moral teachings. Others are mandated by law. The medical profession is no exception to the groups which are subject to certain controls.

While reviewing several medical journals, I noted reports of newly-enacted laws that pertain to the medical profession. I shall not attempt to argue the pros and cons of these laws, though in some instances they were passed by legislative bodies over objections of the representatives of the medical profession.

The 73rd Texas Legislature enacted more than 150 health-related bills, according to the December 1993 issue of *Texas Medicine*. Among them is a requirement that physicians respond to requests for release of medical records within 30 days instead of the original rule of "reasonable period of time". Here is an example of the growing number of legislatively mandated demands on physicians. In this case, there is no acknowledgment of the fact that there could be extraordinary circumstances or that a request for release of medical records might require clarifying correspondence.

Another newly-enacted Texas law, not exclusive to the medical profession, will protect the public against shady advertising. Under the law, all false, misleading or deceptive advertising is now deemed illegal in Texas.

In the November, 1993 issue of *Connecticut Medicine*, a notice from the Department of Public Health and Addiction Services pertains to all health providers who might write "do not resuscitate" (DNR) orders for clients of the department. The statute sets forth specific elements that define an acceptable DNR order.

Effective January 1 in California, every physician who screens or treats breast or prostate cancer will be required to post signs with predetermined wording describing the availability of brochures on these subjects. The signs and the size of print on the signs must be a specific size and must be printed in English, Spanish and Chinese. No mention is made of other forms of cancer or other life-threatening diseases.

No mention is made of other forms of cancer or life-threatening diseases.

Why have I mentioned these three instances? I want our readers to know how the practice of medicine is gradually being encroached upon by legislative bodies. More and more laws increase the complexity of our busy practices, as well as increasing the cost of health care due to the hidden costs of obeying and enforcing the laws. Physicians as a profession are responsible and reasonable, for which some credit seems to be in order. Even though the welfare of our patients is of priority concern, can anyone blame us for questioning the validity of some legislative actions? IM



Marion Alberts, MD

IMS
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The Iowa Medical Society Statewide Physicians Health Program covers nearly 10,000 lives. It has been here for IMS member physicians, their families and employees through Blue Cross and Blue Shield of Iowa for more than 30 years.

The IMS program in 1994 is competitive, has numerous options and is coverage you can count on.

Please contact us at Bernie Lowe & Associates, Inc. We're the administrator/ broker for the Iowa Medical Society Statewide Physicians Health Program.

We can furnish complete information including rates for both traditional and managed care options. We will be happy to assist you in comparing the IMS program with your current coverage.

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How to document CME success

Writing in the *Journal of the American Medical Association* in September of 1992, Weintz and colleagues reviewed the state of continuing medical education. They reflected on the "continuing widespread debate about the form CME should take, who should provide it, the role commercial companies should play in paying for it and how successful completion of specific CME activities should be documented." This last issue merits discussion.

The authors are not referring to the matter of documentation as an administrative process. The key word in the phrase is "successful". The concept of success has nothing to do with enduring a specified number of hours of lecture or workshop. Success relates to how the CME experience improves the practice of medicine.

The medical literature has surprisingly little to say about the outcomes of CME. Therefore, it was a special event to see a publication in the same journal dated December 8, 1993 from the Department of Urology at the University of Iowa.

Medical literature has surprisingly little to say about outcomes of CME.

For the past three years the faculty of that department have organized a highly subscribed course to teach practicing urologists the technique of laparoscopy in an intensive two-day experience. The course included eight hours of lecture, two live case presentations, 4.5 hours of practice with laparoscopy simulators and an additional 4.5 hours in an animal laboratory. The study's authors sought to learn about complication rates following procedures performed by these newly-trained surgeons and any variables that might be associated with the complication rates.

They learned that there was a correlation of complication rates with additional education subsequent to the initial laparoscopy course. Those surgeons who continued their education had fewer complications. As might be assumed, the complication rate decreased as surgeons performed more procedures. Finally, those surgeons who participated in CME with a partner had significantly fewer complications. Although the data did not permit a precise explanation for this latter observation, the authors reasonably assumed that "discourse, feedback and direction provided by a laparoscopically skilled associate could reduce the primary surgeon's risk for complications."

This study has a take-home message. CME can enable the practitioner to acquire new skills; the greater the amount of education the better the patient care outcomes. There is a further message. Education and learning with colleagues (in this situation, extending into the patient case setting) can also improve outcomes.

Not all CME needs to be the "hands-on" experience required to learn a skill like laparoscopy, but the exchange of information with colleagues and the critical assessment of performance are essential. IM



Richard Nelson, MD

Classified Advertising

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Assistant Director Family Practice Residency—Established, community-based, university-affiliated, unopposed 6-6-6-residency enjoys strong hospital and medical community support. We seek a residency-trained, board certified physician. Prior practice experience, including obstetrics, preferred. Position includes teaching and patient care. Administrative responsibilities commensurate with experience. Competitive salary and benefits. Send CV to John Sutherland, MD, Waterloo Family Practice Residency Program, 441 East San Marnan, Waterloo, Iowa 50702; 319/234-4419.

BC Family Physician—Wanted for 50% job share at 17-physician multispecialty clinic in Marshall, Minnesota. Full range of family practice in delightful community of 12,000 with excellent city hospital and Southwest State University. Contact Vince LaPorte, MD, 507/532-9631 MWF or 507/532-5022 Tuesday or Thursday.

Rock Rapids, Iowa, We Need Your Help!—Due to the untimely death of one of our physicians, we are seeking 2 additional board certified/eligible family physicians for a practice opportunity available with Pioneer Medical Center. We provide the full range of family medicine including obstetrics. Offering a guaranteed annual net income and exceptional production incentive. Up to $120,000 is available through the National Health Service Corps for educational loan repayment. Rock Rapids is a community of 2,600 located in northwest Iowa, only 35 miles from Sioux Falls, South Dakota, a metropolitan community of 120,000. Experience the autonomy and comforts associated with small town practice as well as the cultural and recreational conveniences of a big city lifestyle. Contact Jolee Thurn, Sioux Valley Hospital, Physician Placement Program, 1100 South Euclid Avenue, P.O. Box 5039, Sioux Falls, South Dakota 57117-5039. Telephone 1-800/468-3333 or 605/333-7393; fax 605/333-1580.

Immediate Opening—One internist or family practitioner (internist preferred) at a 200-bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $74,640.00. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644. Telephone: 319/334-2583. An Equal Opportunity/Affirmative Action Employer.

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Gastroenterology, Neonatology, Neurosurgery, Occupational Medicine, Oncology, Orthopedics, Orthopedics-Hand—Strelcheck & Associates Inc., an extension of our clients recruiting departments, has positions available in Wisconsin, Michigan, Ohio and West Virginia. We would be happy to provide you with further information. Please call 1-800/243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, Wisconsin 53092.

Cedar Rapids, Iowa—Established all emergency medicine boarded group seeking BC/BP emergency physician to join 6-member group. Brand new ED, highly trained staff, approximately 35,000 ED census. Will be double coverage with 8-hour shifts. Competitive compensation package. Contact: 319/398-6047 or send CV to Mercy Trauma Physicians P.C., 701 10th SE, Cedar Rapids, Iowa 52403-1251.

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Director, Family Practice Residency Program

North Iowa Mercy Health Center, a 368-bed regional referral center, located in north central Iowa, is currently seeking a Director for our well-established family practice residency program. This individual will be responsible for planning, evaluating and coordinating the program and for instructing and supervising family practice residents in their clinical activities.

Qualified applicants must have MD degree or equivalent from an approved medical school and be certified by the ABFP or have suitable equivalent qualifications. License to practice medicine in Iowa is required. Previous experience in administration and clinical teaching is strongly preferred. A minimum of 5 years of experience in a family practice setting and strong leadership skills are required.

This is an excellent opportunity with a competitive salary and comprehensive benefit program. Please send curriculum vitae to:

Human Resources Manager
North Iowa Mercy Health Center
84 Beaumont Drive
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OB/GYN, Internal Medicine, Family Practice—Strelcheck & Associates, Inc. currently represents family practice positions in Pennsylvania, Ohio, Illinois, Minnesota and Wisconsin; internal medicine positions in Wisconsin and New York; ob/gyn position in southeastern Wisconsin. We would be happy to provide you with further information. Please call toll-free, 1-800/243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, Wisconsin 53092.

Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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1701 22nd Street, Suite 201
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515/223-8622

Pediatric and Adult Allergy, P.C.
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Robert A. Colman, M.D.
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515/244-7229
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Fort Dodge 50501
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S. Randy Winston, MD
Douglas R. Koontz, MD
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Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
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Fox Eye Institute
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1400 7th Avenue, Marion 52302
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Iowa Methodist Medical Center
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515/283-6434

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Davenport 52804-1769
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AIR FORCE

A solicitation for your support

The Iowa Medical Society's Education Fund, first called the Scanlon Loan Fund, has been around since the 1950s under various names. This arm of the IMS deserves attention and support as it is in the business of helping people.

The corporate purpose of the IMS Education Fund is "to engage in, assist, further promote and contribute to the support of such charitable, educational and scientific activities and projects" as are, in general, either directly or indirectly related to health or medicine. This charge is a broad one and gives the Fund authority to move forward with various programs which serve the public.

The IMS Education Fund is comprised of the George Scanlon Medical Student Loan Program and the Henry Albert Physician Benevolence and Public Health Fund. The George Scanlon Medical Student Loan Fund is probably the best known among physicians and is the primary activity of the IMS Education Fund. This program honors George Scanlon, a now deceased Iowa City surgeon whose interest and persistence were responsible for the program's creation.

Over $2.5 million has been loaned to about 800 Iowa medical students.

Low interest loans are available to junior and senior medical students with a maximum loan of $6,000 per year. Since its inception, over $2.5 million has been loaned to about 800 Iowa medical students. This loan program is the largest source of nongovernmental funding for students at the University of Iowa College of Medicine. This is something of which we can all be very proud.

The Henry Albert Physician Benevolence and Public Health Fund honors its founder. Dr. Henry Albert was a practicing Iowa physician who stipulated in his will that the proceeds from his estate be used for activities and projects benefiting health and medicine.

Since 1986, this fund has provided $220,813 for various projects. Support has been given to statewide television programs dealing with substance abuse and aging. It has supported child abuse detection education, impaired youth camps, flood relief and our Assistance Program for Troubled Physicians. It has also supported medical student clinical experience in underserved countries as well as the annual Hawkeye Science Fair. This year, it supported the teen Hot Line card, a project of the IMS Alliance. This card was distributed to junior and senior high school students across Iowa and lists toll free hot line numbers for crisis centers dealing with substance abuse, teen pregnancy and other problems. This project has garnered praise across Iowa.



JOHN ANDERSON, MD

We all get lots of requests for donations to various organizations and projects. This month, I join those ranks by asking you to consider a special donation to the IMS Education Fund. Next fall, check the IMS Education Fund box on your dues statement.

On behalf of the 31 medical students who received loan funds this year, I thank you. IM

IMS Update

AT A GLANCE

The headquarters of the Los Angeles County Medical Association suffered significant damage in the late January earthquake. According to LACMA staff, the office suffered damage including buckled floors, a wall pushed out of alignment and large cracks in a stairwell.

The IMS continues seeking nominees to receive the first annual Physician Award for Community Service. The award will honor an Iowa physician who has provided outstanding civic, charitable and health services to patients and the community. Contact Tina Preftakes at the IMS with your nominee by April 1.

An Open Forum on Health System Reform will be held Saturday, April 16 in conjunction with the 1994 IMS Annual Meeting. Check the ***Health System Reform*** *section for more details.*

Calling all IMS delegates

IMS delegates from across Iowa are urged to represent their counties at the 1994 IMS House of Delegates and Scientific Session April 15-17 at the Hotel Savery, Des Moines.

The Scientific Session begins with a full day of programs on Friday and concludes with a panel discussion on Sunday morning. (A complete program and registration information is enclosed with this *Iowa Medicine*.)

Election of officers will be held on Sunday morning, April 17. Offices to be filled include president, vice-president, trustee, House of Delegates speaker and vice-speaker, three AMA delegates and one AMA alternate delegate.

A special **Forum on Health System Reform** is planned for 10:30 a.m. Saturday, following an abbreviated House of Delegates session. (See the **Health System Reform** section for more details and a registration card.) The forum will be followed by lunch and IMS reference committee hearings.

IMS delegates should watch their mail for more information about the meeting, resolutions which have been submitted, the slate of officer candidates and delegate handbooks.

Board meets with UI officials

The IMS Board of Trustees held a recent conference with officials of the University of Iowa to discuss plans for an organized delivery system in the Iowa City area, perhaps extending into Illinois.

Those attending included Henri Manasse, vice president of Health Sciences; John Staley, interim director of UI Hospitals and Clinics; and Richard Lynch, MD, interim dean of the UI College of Medicine. The group agreed to keep Iowa physicians apprised of future plans.

The IMS Board also met with Richard Nelson, MD, associate dean of the UI College of Medicine, regarding the College's primary care initiative.

Specialty group for county MEs

A new group for county medical examiners is currently being formed with administrative support from IMS Services.

The Iowa Association of County Medical Examiners is created to give county medical examiners an opportunity to exchange information and educate physicians about Iowa law covering death investigation and responsibilities of county MEs. The group will also represent county MEs before state agencies.

A pro-tem board has been appointed for the group. The board includes:

Dale Andres, DO — president

Daniel Cole, MD — vice president

Hunter Hansen, DO — secretary/treasurer

Christopher White, MD; RC Wooters, MD; Albert Dolan, MD; Arthur McMahon, MD; and Paul Beckman, MD — board members.

For more information about this new specialty group, call Dave Furneaux of the IMS staff, 515/223-1401 or 800/747-3070.

Specialty Society Update

The Iowa Academy of Otolaryngology held a meeting in late February with BCBSI officials to discuss implementation of an RBRVS fee schedule for surgical services.

The American College of Cardiology, Iowa Chapter, is urging its members to attend the Iowa Medical Society's Forum on Health System Reform at the Savery Hotel in Des Moines at 10:30 a.m. Saturday, April 16. The ACIC will hold a closed meeting at the Savery directly after the IMS Forum.

The Iowa Medical Group Management Association's Spring Meeting will be May 4-6, 1994 at the Des Moines Marriott Hotel.

The Iowa Affiliate of the American Medical Directors Association will hold its 1994 spring meeting March 17 in Des Moines.

The Iowa Oncology Society will hold its 1994 annual meeting on October 28 in Cedar Rapids.

Iowa physicians protest *McCall's* ad

Five Fairfield physicians have sent a letter of protest to *McCall's* regarding an information request in a recent issue of that magazine. The letter, signed by physicians practicing in the Medical Arts Clinic, PC, said the group is also cancelling its magazine subscription and is urging other physicians to do the same.

The item appearing in the magazine said: **"Attention health care vigilantes: Has your doctor ever failed to suggest a certain treatment or make the right diagnosis? We'd like to hear your comments. Write to Medical Error, *McCall's*, 110 Fifth Ave., New York, NY 10011."**

In their letter to *McCall's*, Drs. Donal Hill, Terry Cochran, Winn Gregory, Michael Greiner and Joseph McNerney said they find the magazine item "offensive to our profession."

"Physicians do our best to achieve quality care for all patients. The practice of medicine does not come with a guarantee but rather a promise to provide quality care, appropriate at the time of service, in an ongoing physician-patient relationship."

The AMA also plans to write *McCall's* a letter expressing concern over the news item.

The *McCall's* address is: *McCall's*, PO Box 3178, Harlan, Iowa 51537-0369.

JAMA publishes tobacco issue

The February 22 issue of the ***Journal of the American Medical Association*** focuses on tobacco. The AMA held a media briefing in New York to promote the special issue.

Featured stories in the magazine include results of a 50-year study on smoking by adolescent girls, predicting who will quit, nicotine patch therapy, environmental tobacco smoke and physicians' role in helping patients quit.

IMS Board meets with newspaper editors

The IMS Board of Trustees recently held a very interesting meeting with editors of local newspapers from across Iowa.

The group discussed the media's coverage of health system reform and issues such as access to health care in rural Iowa.

The editors said they would like to get medicine's perspective before the public but often have difficulty finding local physicians who will be interviewed.

Any Iowa physicians willing to be media spokespersons in their area on various issues are urged to contact Chris Clark, IMS director of communications, at 515/223-1401 or 800/747-3070. Watch future issues of *Iowa Medicine* for information about media spokesperson seminars.

Focus on IMS Alliance

In preparation for this year's Iowa Legislature, the Alliance worked with Paul Bishop, IMS legislative liaison, to organize the phone bank. Coordinators and back-ups were identified across the state. The hotline number is no longer being used. In its place, a fax will be sent to key contacts when a legislative alert is issued.

There is still a little time to submit nominations for the Alliance Member of the Year award. Send your nominations to Sandy Nichols at IMS headquarters.

Contributed by Judy Hoenk, IMSA president

Support group for impaired physicians

CADUCEUS Alcoholics Anonymous is available for physicians and/or spouses. The group meets every Monday from 6:30 to 7:30 p.m. at 1313 High Street, Room 320 in Des Moines. According to Dr. Stan Haugland, organizer of CADUCEUS AA, the meetings usually involve 13-15 medical doctors and dentists. There is no cost and no records are kept.

The meetings give physicians the opportunity to share unique problems which physicians would have difficulting sharing at a regular AA meeting, such as monitoring by the dental or medical board.

Strictly confidential inquiries should be directed to Dr. Stan Haugland, 515/241-6021.

Physicians are reminded that the IMS sponsors an Assistance Program for Troubled Physicians (APTP). The APTP, funded by the IMS Education Fund, is a non-punitive voluntary program through which physicians who have trouble with substance abuse are encourated to seek treatment. In conjunction with the APTP, the IMS Alliance operates HELPLINE for spouses and family of troubled physicians. For more information about these programs, call Tina Preftakes at the IMS. IM

The group is cancelling its subscription and urges other physicians to do the same.

Health System Reform

AT A GLANCE

The Iowa Chapter of the American College of Cardiology plans to hold a meeting in conjunction with the IMS House of Delegates so its members may attend the IMS Forum on Health System Reform April 16.

The AMA is urging physicians and medical societies to contact their senators and congressmen to endorse antitrust relief legislation introduced by Senator Orrin Hatch and Representative Bill Archer as the Health Care Antitrust Improvement Acts.

The AFL/CIO has set aside its bitterness over NAFTA and its preference for a single payer system and has endorsed the President's health reform plan. AFL/CIO president Lane Kirkland said the group will be "aggressive players" in the national debate on health system reform.

Register for Forum on Health System Reform

Don't miss the tear-out registration card for the IMS Forum on Health System Reform which is included with this section of *Iowa Medicine*. Just complete the card and drop it in the nearest mailbox. No postage is necessary.

The Forum on Health System Reform will be held at 10:30 a.m. Saturday, April 16 in conjunction with the 1994 IMS House of Delegates meeting at the Savery Hotel in Des Moines. It will include a presentation by Nancy Dickey, MD, AMA trustee, on health system reform at the national level and a summary of health system reform in Iowa by Dr. William Eversmann of the Governor's Health Reform Council.

A panel consisting of representatives of selected specialty societies will give an overview of their proposals. Groups represented will include the Iowa Academy of Family Physicians; American Society of Internal Medicine, Iowa Chapter; American College of Surgeons, Iowa Chapter and the American Academy of Pediatrics, Iowa Chapter.

An open question and answer session will be a key component of the forum. Luncheon will be served following the forum. Physicians are welcome to attend hearings of IMS Reference Committees beginning at 1:00 p.m. (These committees consider resolutions submitted by Iowa physicians for adoption as IMS policy.)

IMS adopts policy on reform financing

The IMS Executive Council has approved several policy statements with regard to financing of health system reform. These statements were recommended by the Society's Ad Hoc Committee on Health System Reform and are now official IMS policy:

- The IMS reaffirms support for universal health coverage and universal access to health care services.
- The IMS believes a broad range of strategies including individually mandated insurance, mandated employer conduit, employer mandated insurance and health care savings accounts are acceptable alternatives to accomplish universal health insurance coverage and access to health care services.
- The IMS reaffirms the authority of its Board of Trustees to modify policy regarding health system reform when and where necessary to assure the IMS has adequate flexibility as it engages in negotiations, staying within the principles of health system reform adopted by the IMS Executive Council.

Committee continues study of IPA issues

At press time, an IMS ad hoc committee continues studying the feasibility of creating a statewide Independent Practice Association (IPA). The group plans to make a recommendation to the IMS Board of Trustees in time for its March 16 meeting.

The ad hoc committee was formed in mid-1993 at the direction of the IMS House of Delegates and was charged with making a recommendation on whether the IMS should create an IPA. Proponents of a statewide IPA believe it will give physicians more leverage to negotiate fees within the constraints of anti-trust laws.

John Rhodes, Jr., MD of Pocahontas is chairman of the 10-physician committee.

Initially, the Board planned to retain a consultant to work with the committee. However, due to the cost of consulting services, the Board decided to ask the committee to provide a preliminary evaluation. At a mid-February

Worth Repeating

"We told him to keep government's hands off health care." Gary LaFrenz, president of Ford Lincoln Mercury in Mason City.

Mr. LaFrenz was one of about 20 small business owners who met recently with Senator Tom Harkin regarding health system reform.

Registration Card

Iowa Medical Society • Forum on Health System Reform

April 16 • 10:30 a.m. • Hotel Savery • Des Moines

Registration is easy. Complete this card, tear it out and drop it in a mailbox, no postage required!

Name (Please print) _____

City _____ Specialty _____

Are you an IMS delegate or alternate delegate? Yes _____ No _____

Mini-Survey of Iowa Physician Opinion

Of the health reform proposals you are familiar with, which one will fulfill the reform goals you believe are important? (Check one)

Clinton Plan _____

Canadian-type system _____

Cooper-Grandy bill _____

Chafee plan _____

AMA's Health Access America _____

Don't know yet _____

Other _____

_____



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meeting, the ad hoc committee heard presentations from Dan Langfield, director of Eastern Iowa Health Care; Mike Stoll, president of Tri-State IPA; and William Mobley, MD, president of Eastern Iowa IPA.

Watch the April *Iowa Medicine* for more information on the committee's recommendation and the IMS Board of Trustees action.

AMA announces reform priorities

In the wake of confusing media reports, the AMA has assured President Clinton that its support for universal coverage remains intact.

The AMA clarified its position due to what it called misleading press reports regarding expansion of AMA policy to support several options besides an employer mandate for achieving universal coverage.

The AMA has also announced its official health system reform priorities for 1994. They include:

- Universal coverage.
- Assurance that physicians, as advocates for their patients, play a significant role in deciding how health care is delivered and financed.
- Guarantees that all patients have a choice of health plans and physicians.
- Reforms in the tort system like those in California.
- Relief from restrictive antitrust laws which prohibit physicians from negotiating quality of care and conditions of patient coverage with insurance and hospital plans.
- Creation of a new public/private partnership to set and monitor national quality standards.

Economists enter health care debate

A group of 565 economists, including Nobel laureate Milton Friedman, has sent a letter to President Clinton urging him to remove price controls from his health system reform plan. The economists argue that caps, fee schedules and other government regulations may appear to reduce medical spending but instead lower quality, reduce medical innovation and create expensive new bureaucracies to monitor compliance. Such price controls, they said, will hurt people and the economy.

In addition, Alain Enthoven, one of the "fathers" of managed health care, is criticizing the price controls contained in the Clinton plan. Enthoven said the Clinton plan sets "extremely unrealistic" goals for health care cost increases and that workers could see new taxes as high as 12% of salary tacked onto their paychecks to cover the cost of President's plan.

Clinton administration health policy advisors disputed the criticism, saying the proposed premium caps are not price controls and that the Clinton plan will foster more competition.

In the meantime, the White House has adopted the stance that action on welfare reform must be delayed until after its health system reform plan clears Congress. The strategy evoked a strong response from Senator Pat Moynihan (D-NY) who threatened to hold the Clinton bill hostage until progress is made on welfare reform. He was quoted in the press as saying "We don't have a health crisis, we have a welfare crisis and we can do both."

Such price controls, they said, will hurt people and the economy.

AMA ad in *Wall Street Journal, Post*

A series of AMA ads is now appearing in the *Wall Street Journal* and the *Washington Post.*

In late January, the AMA placed an ad with the headline "Would you rather trust your life to an MD or an MBA?" The ad was designed to make the point that physicians should be setting standards for quality of care.

"Bureaucrats may have good intentions, but they don't have the scientific knowledge and training to make such decisions," the ad said. "That's why 300,000 members of the American Medical Association are working to make sure the final plan guarantees physicians will keep primary responsibility for setting standards of medical care."

Pharmaceutical industry launches ad campaign

Stung by criticism over allegedly excessive pricing, the pharmaceutical industry has launched a national television advertising campaign to improve its image. The campaign, which will cost about $12 million and last for one year, is a first for the industry. The commercials will air daily during the network morning news shows and evening newscasts.

Turn the page to find a chart comparing the AMA's Health Access America proposal and 5 major health system reform plans being debated in Congress!

Health System Reform

continued

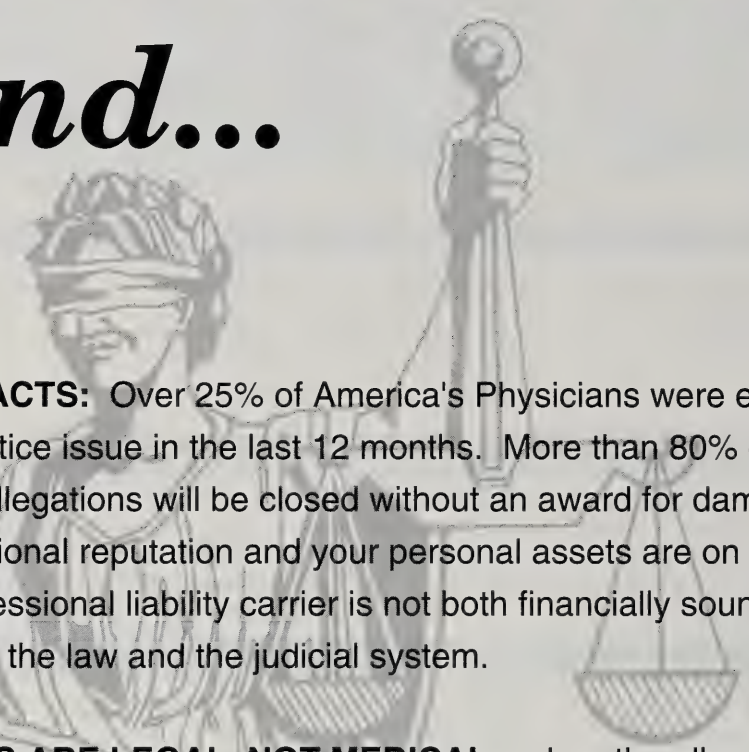
6 REFORM PROPOSALS . . .

1 AMA Plan *Health Access America*	2 Clinton Plan	3 Cooper-Grandy Plan Rep. Jim Cooper, D-Tennessee Rep. Fred Grandy, R-Iowa
ADMINISTRATION		
No new bureaucracy.	National health board reviews benefits, sets standards. States run purchasing cooperatives. Insurance companies compete based on price and work through cooperatives.	National health board. States must set up regional purchasing cooperatives. Insurance companies compete based on price.
BENEFITS		
Similar to Clinton plan except stronger on preventive services. Mental health and substance abuse problems covered at same level as other medical conditions.	Doctor and hospital bills, prescription drugs, preventive care, dental care under 18, mental health, substance abuse. Limited, phased-in long-term care but not for nursing homes.	To be established by a national commission and approved by Congress.
COST CONTAINMENT		
Negotiate goals and increase competition through consumer choice, fair tax incentives, insurance reform, administrative simplification and tort reform.	Providers, insurers compete to provide best prices to purchasing cooperatives. Cap on insurance premiums. Administrative, malpractice reform.	Providers, insurers compete to provide best prices to purchasing cooperatives. Administrative, malpractice reform.
CHOICE OF PHYSICIAN		
Patients can choose any physician or health plan, including fee-for-service, HMO, PPO or benefit payment schedule plan.	Patients pick from three accepted health plans; can seek more expensive coverage outside the plan.	Patients can choose any health plan offered.
ELIGIBILITY		
Universal coverage of legal residents through reasonable, guaranteed coverage which may include employer-required insurance, individual-required insurance, individually-owned insurance and health IRAs.	Universal coverage of legal residents, largely through employers. Medicare separate, Medicaid partially folded into cooperatives.	Improved access, not guaranteed coverage, through employers, cooperatives and insurance market reform. Medicare separate, Medicaid folded in.
FINANCING		
Shared employer, individual and government participation, with broad-based taxes. No cuts in Medicare or Medicaid.	Employers pay at least 80% of premiums. Copayments and deductibles. Subsidies for low income, small businenss. Full tax deductions for self-employed. Medicare, Medicaid cuts, tax hikes on tobacco, nonparticipating corporations.	Premiums, copayments and deductibles. Limits on employer tax deductions for insurance costs. Reduced Medicare spending. Government subsidies for low-income, tax deductions for self-employed.
ASSESSMENT		
Provides basis for AMA to negotiate with Congress. Emphasis on unversal coverage, reform based on competition and *less* regulation.	President and Mrs. Clinton have said most provisions are open to compromise except universal coverage and cost containment. Major changes likely.	Pure managed competition theory without Clinton employer mandates and premium caps is less ambitious, less costly. Could command middle ground.

A side-by-side comparison

4 Chafee Plan Sen. John Chafee, R-Rhode Island	5 Michel Plan Rep. Bob Michel, R-Illinois	6 Gramm Plan Sen. Phil Gramm, R-Texas
ADMINISTRATION		
National health board. States may set up regional purchasing cooperatives. Insurance companies compete based on price.	National health board. States may set up regional purchasing cooperatives. Insurance companies compete based on price.	No new bureaucracy.
BENEFITS		
Preventive care, prescription drugs, some home health care, mental health and substance abuse coverage. Standard plan or catastrophic policy with high deductible and tax-free medical savings account.	To be established by national commission. Options include standard plan or catastrophic policy with high deductible and tax-free medical savings account.	Not specified. Options include standard plan, HMO and high-deductible catastrophic plan with tax-free medical savings account.
COST CONTAINMENT		
Some use of purchasing cooperatives. Administrative, malpractice reform.	Some use of purchasing cooperatives; administrative and malpractice reform. Limits on small business rate increases.	Relies on market forces rather than purchasing cooperatives.
CHOICE OF PHYSICIAN		
Patients can choose any health plan offered.	Patients can choose any health plan offered.	Patients can choose any health plan offered.
ELIGIBILITY		
Universal coverage of legal residents through individual's requirement to purchase insurance.	Improved access, not guaranteed coverage, through employers, cooperatives and insurance market reform.	Improved access, not guaranteed coverage, through insurance market reform. Incentives for reduced rates based on health-related behavior.
FINANCING		
Premiums, copayments, deductibles. Medicare, Medicaid cuts. Limits on employer tax deductions for insurance. Phased in subsidies for low-income once savings materialize. Tax deductions for self-employed.	Premiums, copayments and deductibles. Cuts in other government programs. Phases out Medicare for wealthiest recipients. Subsidies for low-income people. Tax deductions for self-employed.	Premiums, copayments and deductibles. Reduced Medicare and Medicaid spending. Tax deductions for self-employed.
ASSESSMENT		
Closest of Republican plans to political center, could attract Democratic support.	Fine-tunes current system rather than making major changes. Could become basis for phased-in reform.	Most conservative; incentives for healthful behavior. Uninsured might have to exhaust assets.

...a promise to defend...



HERE ARE THE FACTS: Over 25% of America's Physicians were embroiled in a malpractice issue in the last 12 months. More than 80% of those malpractice allegations will be closed without an award for damages. Your professional reputation and your personal assets are on the line when your professional liability carrier is not both financially sound *and* experienced in the law and the judicial system.

WHEN THE ISSUES ARE LEGAL, NOT MEDICAL-- when the allegations are frivolous, or highly emotional-- you need a company and legal representation that understands the problem and has the experience to resolve the issue. The Medical Protective Company has specialized in defending doctors since 1899. Our legal and claims management experience is unmatched by any other insurer in the U.S.

FOR MORE INFORMATION on how we can protect your professional reputation and your personal assets, call your local Medical Protective General Agent at 1-800-344-1899.

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Legislative Affairs

Legislature debates fiber optics

The IMS hopes to convince lawmakers to allow the Iowa Communications Network (ICN) to be used for telemedicine purposes by physicians. In a letter to Brent Siegrist, majority leader of the Iowa House of Representatives, Dr. John Anderson, IMS president, said it is vital that physicians be included.

"While it is unlikely solo or small group practices will wish to invest in the necessary equipment in the near future, larger physician clinics could make good medical use of the network and find such an investment cost-effective for patients."

In his letter, Dr. Anderson pointed out that most of the discussion of telemedicine has focused on allowing hospitals to gain access to the Iowa Communications Network but that "state law should treat both hospitals and physician clinics equally in providing access." (Teaching hospitals will be part of the ICN.)

IMS believes statewide access to fiber optic technology can accomplish several purposes: 1) extend specialist care to all areas of the state; 2) improve access to continuing education opportunities for physicians and other practitioners; 3) provide access to the latest medical information through multimedia textbooks and computerized patient simulations.

There is concern that expanding access to the ICN would replace services currently being provided by the private sector. Dr. Anderson said the IMS will work with legislators and others to ensure the ICN is not used in such a way.

The Iowa Legislature has been debating whether to make another financial commitment necessary to bring schools and libraries (the original entities the ICN was intended for) into the system.

Controversy has arisen over the amount of money that has already been spent on fiber optics and whether or not the state should make an additional and, as yet undetermined, financial commitment.

IMS Legislative Day

All IMS physicians and Alliance members should have received a mailing giving details of the IMS Legislative Day scheduled for Tuesday, March 15. This will be an opportunity to observe the Iowa Legislature in action. A briefing and luncheon will be held at IMS headquarters prior to the trip to the capitol.

For more information, call Becky Roorda or Lyn Durante at 515/223-1401 or 800/747-3070.

AMA pushes antitrust legislation

The AMA has announced specific goals it will work to achieve during 1994 and antitrust relief is at the top of the list.

Under current antitrust law, physicians who engage in negotiations are threatened with criminal prosecution or costly civil litigation. "This state of affairs is simply unacceptable as a matter of health care policy and fundamental fairness," says an AMA policy statement.

The AMA proposes:

•legislation that facilitates formation of physician sponsored and directed health care delivery networks by authorizing physicians to form these entities.

continued next page

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50309

You may contact your legislator at home when the Legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, contact Lyn Durante of the IMS staff at 515/223-1401 or 800/747-3070.

AT A GLANCE

Physicians across the nation are scheduled to attend the AMA's meeting "Partnership in Action: Uniting for America's Health" to be held March 8 in Washington, DC. The physicians hope to send a clear message to Congress: pass a reform bill which ensures physician involvement in the delivery system.

Two of the most senior Democrats in the U.S. House of Representatives have announced they will not seek reelection this year. This makes 32 members of the House who have declared plans to retire or seek higher office.

It is anticipated that the Iowa Legislature will adjourn on time or perhaps a few days early this year. Legislators' reimbursement is scheduled to end April 19.

March 19 at 5 p.m. is the last day for candidates for federal, statewide and legislative offices to file for election in 1994.

Legislative Affairs

continued

Want to be a political "insider"? Attend the free IMS seminar on how to be part of a political campaign. The seminar, will be held June 8 at IMS headquarters and is open to all IMS physicians and spouses. For more information, call Paul Bishop or Lyn Durante at 515/223-1401 or 800/747-3070.

•antitrust reform which allows safe harbors for formation of physician groups representing up to 35% of the physicians in a market in exclusive networks and 50% in nonexclusive networks. AMA says these percentages may need to be adjusted in rural areas.

•legislation directing non-physician sponsored health plans to create committees of physicians in the plan. These physicians would provide input about coverage, medical review criteria for coverage decisions and credentialing of physicians and other matters.

•legislation under federal law for negotiated rulemaking, backed up by binding arbitration for dispute resolution, as the primary method for developing federal health care regulations, with AMA as the profession's lead negotiator.

•standards set by physician organizations in areas such as practice guidelines, outcomes measurement and reporting and performance standards. Medical societies would conduct medical peer review activities and mediate fee disputes between patients and physicians.

Bills of interest in the Iowa Legislature

The following bills of interest to the IMS have been introduced in the Iowa General Assembly:

Key to IMS position on bills

FOR	For
AG	Against
AM	Amend
MON	Monitor

HF 2012 Parental Notification of Abortion. Requires physicians to notify parents prior to performing an abortion on a minor. Minor may request judicial bypass of the requirement where parental notification may not be in the minor's best interest (such as where physical abuse is the likely result). AG (Position paper available)

HF 2017/SF 2061 Licensure of Athletic Trainers. Requires state licensing of athletic trainers and practice under the supervision of an MD, DO or "other appropriate practitioner". AM

HF 2028/HF 2037/HF 2038 Civil commitment procedures. Various bills propose changes in involuntary commitment procedures for the mentally ill. MON

HF 2065/SSB 2043/HSB 538 Communicable Diseases Quarantine. Allows the Iowa Department of Public Health to quarantine or monitor patient compliance with treatment for communicable diseases. The bill has been requested to ensure that tuberculosis patients comply with the prescribed treatment regimen. Several county attorneys say Iowa's quarantine laws, decades old, do not cover this situation. FOR

HF 2069 Licensure of Orthopedic Physician Assistants. Would require orthopedic PAs to be licensed to practice in Iowa. The bill sets up a board of orthopedic physician assistant examiners and requirements for licensure. AG

HJR 2004/SJR 2001 Marijuana for Medical Purposes. Asks the federal government to allow prescribing of marijuana for medical use. AG

SF 2009/SF 2043/SSB 2007/HSB 566/SSB 2088 Child Abuse Laws. All attempt to improve the system of dealing with child abuse, including increasing penalties for skeletal injuries and making other changes. MON

SF 2018 Mandated Insurance Coverage for PA Services. Would require health insurers to provide coverage for services provided by a physician assistant if the same services are covered when provided by a physician. AG

SF 2053 Nurse Practitioner Prescribing. Expand nurse practitioners' prescribing authority to include controlled substances, remove participation of the board of medical examiners in prescribing rules and allow CRNAs to prescribe controlled and noncontrolled drugs. AG

SF 2062/HSB 513 Nonblinded HIV Studies. Authorizes the Department of Public Health to conduct nonblinded HIV studies with the approval of the state Board of Health. Informed consent and reporting and counseling requirements of the Code would apply . FOR

SSB 2005/HSB 571 IMS and Tobacco Free Coalition Anti-tobacco Bill. The bill expands the provisions of the existing Clean Indoor Air Act and gives the Iowa Department of Public Health the authority to enforce the Act. FOR

SSB 2016/HSB 512 Iowa Department of Public Health Recommendations. Makes various changes including eliminating physician reporting of brain injuries (hospitals would continue to report), continuing existence of Health Data Commission until CHMIS is underway and add HIB to the vaccines required for children entering licensed day care or school. FOR

SF 2069 Community Health Management Information System. Sets up an electronic system for data collection and health insurance claims billing and reimbursement. FOR

SF 2084 Nurse Practitioner Insurance Reimbursement. Requires health insurers to cover a service provided by a nurse practitioner if it is within the nurse practitioner's scope of practice and is covered when provided by a physician. AG IM

If you would like more information or IMS position papers on any legislative issue, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

Medical Economics

Rules on fees for patient record copying

The Iowa Medical Society has expressed concern over proposed rules related to setting maximum fees for copies of medical records in workers' compensation cases. In a letter to the chief deputy industrial commissioner of the Department of Employment Services, Dr. Kevin Cunningham, chairman of the IMS Committee on Legislation, said there is "no established authority for the industrial commissioner to set fees for physicians" and that the Iowa Code provides a mechanism for addressing disputes over physician charges.

Dr. Cunningham's letter also took exceptions to the specifics of the proposed rule and expressed the Society's willingness to work with affected parties on an alternative.

Medicaid spending decrease continues

The decrease in the growth of Medicaid spending appears to be continuing for the first six months of FY 1994, but officials from the Department of Human Services say it's too soon to tell if the rate of decrease will continue.

According to Don Herman, director of the Department of Human Services, the state is currently spending less than the amount budgeted for acute care services for Medicaid patients.

In addition, it appears the physician cost per patient visit in FY 1994 will decrease for the third time since FY 1991.

"Some of these figures could change when we receive data from the peak flu months," Herman comments. However, it is interesting to note that other states are not experiencing the same decreases in program growth.

Putting aside the seasonal flu variations, he says the growth in managed care and the prior authorization program for prescription drugs have been key factors in spending decreases.

Iowa currently has 66,000 of its 220,000 Medicaid enrollees in managed care plans. The DHS hopes to increase that number to 108,000 by June of this year.

"A greater focus on primary care helps avoid inpatient hospitalizations," he comments. Also, the prior authorization program for prescription drugs has caused physicians to prescribe lower cost alternatives, Herman adds.

The budget request currently before Iowa lawmakers contains no reimbursement increases other than a 10% increase for Medicaid obstetrical services. The DHS is asking the legislators to appropriate funds for a plastic Medicaid identification card program to replace the monthly paper system. Plastic IDs for Medicaid patients will increase efficiency, save time for providers and save postage costs, say DHS officials. Providers will be able to verify eligibility of as many as 20 patients at once through a computer.

COLA accreditation approved

The Commission on Office Laboratory Accreditation (COLA) has been granted deeming authority by the Health Care Financing Administration. This means laboratories accredited by COLA are deemed to meet federal standards for CLIA inspections. Accreditation by COLA fulfills nearly all CLIA requirements and allows labs to avoid the routine government inspection. COLA is the only accrediting organization for the office laboratory which has obtained deeming authority by HCFA.

There are no recent changes in CLIA requirements governing physician laboratories.

Electronic billing of Medicare claims

Under a new Medicare claims system, local Medicare contractors such as Blue Cross and Blue Shield of Iowa will be doing more customer service work and less data processing.

GTE Government Systems Corporation has been awarded a $19 million contract to lay

continued next page

AT A GLANCE

The Supreme Court of Minnesota has granted a petition for expedited review of a lawsuit filed on behalf of physicians in Iowa and several other states from whom Minnesota is attempting to collect a health care tax. The suit, filed by the AMA, contends the tax is unconstitutional. Watch future issues of Iowa Medicine *for the latest developments.*

HCFA has sent a letter to state Medicaid directors telling them they must cover abortions when a woman is a victim of rape or incest. Pro-life advocates and some state officials are crying foul, saying the White House reneged on a promise to honor state laws on the issue.

Medical Economics

continued

groundwork for electronic billing of nearly all Medicare claims. The new system will be brought on line starting in late 1996 and will be installed nationwide by late 1998.

The new Medicare transaction system is designed to help patients and providers out of a "modern-day maze" of red tape, said Donna Shalala, Health and Human Services secretary.

By the turn of the century, the new system will handle 1 billion claims a year and will save the government $200 million annually in streamlined adminstrative costs.

The new system will handle 1 billion claims and save the government $200 million annually.

The current Medicare claims system relies on 79 contractors using 14 different computer systems in 62 sites.

IFMC Director election results final

Incumbents have been reelected to all eight physician positions on the IFMC Board of Directors, the IMS has learned.

Ballots in the election were mailed to all physician members eligible to vote for the position in a particular county or district.

Incumbents reelected to four County Representative Director positions (MD) are: John Brehm, MD, Dubuque; Robert Reiter, MD, Iowa City; Harlan Rosenberg, MD, Des Moines; David Zuehlke, MD, Sioux City.

Incumbents reelected to three Area Representative Director Positions (MD) are: David Thomas, MD, Marshalltown; Larry Goetz, MD, Creston; Brian Ford, MD, Spirit Lake.

Rick Kellenberger, DO, West Bend, was reelected to the Area Representative Director Position (DO).

Update on Blues merger

Last May, Blue Cross and Blue Shield of Iowa and Blue Cross of South Dakota announced an impending merger with Blue Cross and Blue Shield of Illinois. The boards of directors of the two companies have agreed on the following basic merger terms:

- The company will be domiciled in Illinois, organized under Illinois law and subject to regulatory authority of the Illinois insurance director. However, the company will have its headquarters (including the offices of the chief executive officer and staff) in Des Moines.
- Robert Ray, current president and CEO of the IASD Health Services Corporation, will serve in that same capacity for the parent company. Raymond McCaskey, president and CEO of the Illinois Plan Health Care Service Corporation (HCSC), will serve as executive vice president.

The new parent company will be governed by a new board of directors drawn from the current HCSC and IASD boards. John Colloton, IASD board chair, will serve as vice chair of the new company's board.

In a letter to the IMS, Robert Ray said existing contracts with current providers will remain in place and policyholders will experience no disruptions in benefits or services. State and federal regulatory approvals are now being sought for the merger, and the goal is to complete this process by mid-1994. IM

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

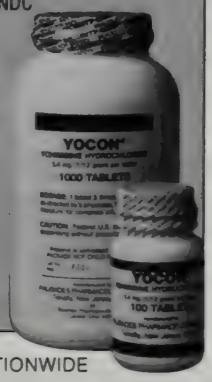
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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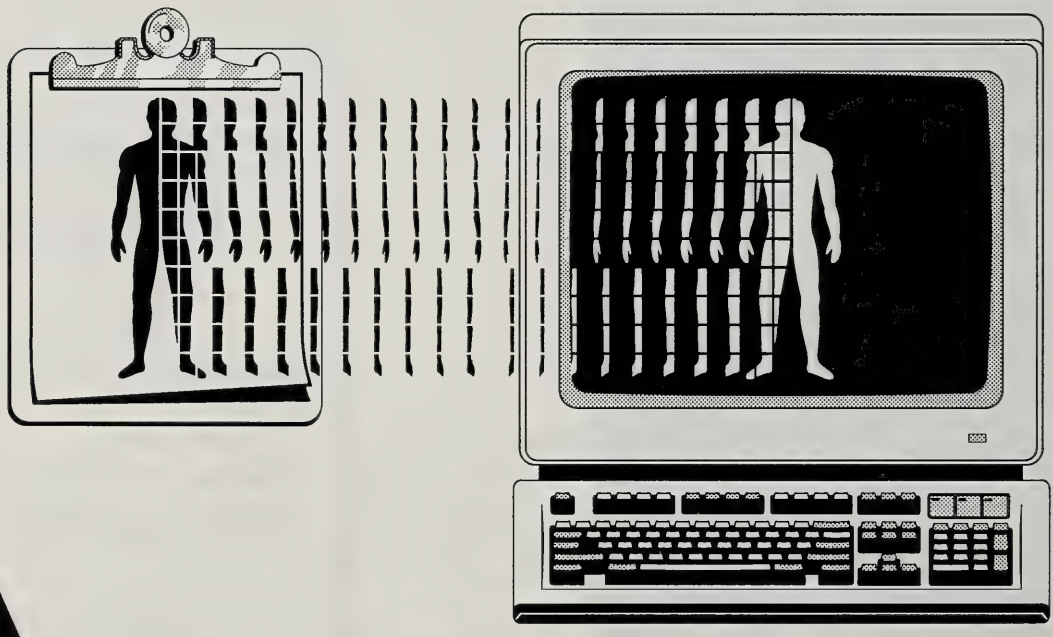
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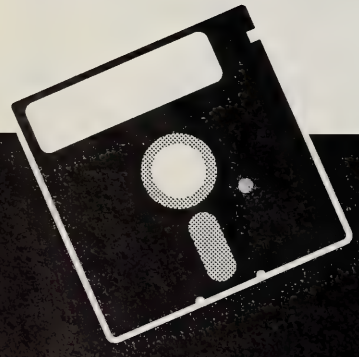
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Practice Management

An overlooked source of revenue

Are you overlooking outstanding accounts as a source of revenue for your practice? In April, IMS Services will offer seminars on billing and collections in Cedar Rapids and Mason City. (See box on this page for details.)

The seminar covers Iowa law, which is very specific with regard to bill collecting. Physician office staff are advised to stay current on these statutes to make sure bill collections are being done correctly.

The Iowa Medical Society endorses I.C.Systems, which specializes in medical practice collecting. I.C. Systems has a videotape called "Collection Strategies for the Reluctant Collector".

For more information about purchasing the tape or about the IMS Services seminar, call Barb Cannon at 515/223-1401 or 800/747-3070.

Ensuring patient satisfaction

Don't miss the feature article in this *Iowa Medicine* on how to ensure patient satisfaction in today's competitive market.

The article is written by William Walsh, a nationally-recognized expert in marketing for medical practices. The article contains some excellent information, particularly in the area of patient satisfaction surveys.

Mr. Walsh has been a presenter at several IMS Services seminar.

Have you thought about retirement?

IMS Services is offering a series of seminars for member physicians and spouses interested in retirement planning. Five one-day programs will be offered this spring. (See box on this page for dates and locations.) Topics to be discussed at the seminars include: how to get the most growth from what you have, how to control taxes and emotional readiness for retirement. Participants will receive a notebook to organize personal data and have the option of receiving a comprehensive, personalized financial report.

The workshop presenter will be Jerry Foster, president of Retirement Advisors, Inc. For more information, call Sherry Johnson at 515/223-1401 or 800/747-3070.

1994 practice management offerings

IMS Services is offering valuable seminars on a number of topics this year:

Quality in the Office Practice, Office Safety and Compliance, Health Insurance Overview, Medical Terminology, Office Team Skills, ICD-9-CM Coding, CPT Coding, Valuing Your Practice, Closing Your Practice, E & M Coding Review and Case Studies and Rap Groups for Pediatric Practice and Family Practice Residency Programs. If you missed February's mailing on 1994 IMS Services seminars, call Sherry Johnson at 515/223-1401 or 800/747-3070.

Upcoming Workshops for You and Your Practice

"Plan Ahead for Financial Security"

Have you thought about retirement? No matter when you plan to retire, your success will depend on advance planning. If you are interested in retirement planning, try one of these four spring programs for Iowa physicians and their spouses.

Tuesday, April 5
Mercy Hospital
Iowa City

Thursday, April 28
Mercy Hospital Board Room
Dubuque

Tuesday, May 3
Marion Health Center
Sioux City

Thursday, May 19
Allen Memorial Hospital
Waterloo

For more information about any workshop or seminar listed here, call Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

AT A GLANCE

HCFA has released new guidelines which say all Medicaid-eligible children ages 6 to 72 months are considered at risk for lead toxicity and must be screened. The provider must discuss lead poisoning interventions with the child's parents and assess the child's risk for exposure. For technical assistance, call the IDPH, 800/972-2026.

Thirty-one people including 12 MDs and DOs have attended two sessions of the American College of Medical Practice Executives's Management Education Program (MEP), cosponsored by the IMS and IMGMA. The program is a mini-MBA with 10 topics geared to practice management. Faculty are from across the nation.

Practice Management

continued

Physicians may face liability or disciplinary action for inappropriate release of records.

Focus on Risk Management

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Because reproducing and releasing records is becoming so time-consuming, many clinics are considering using a copy service. The choice for your clinic depends on a variety of factors.

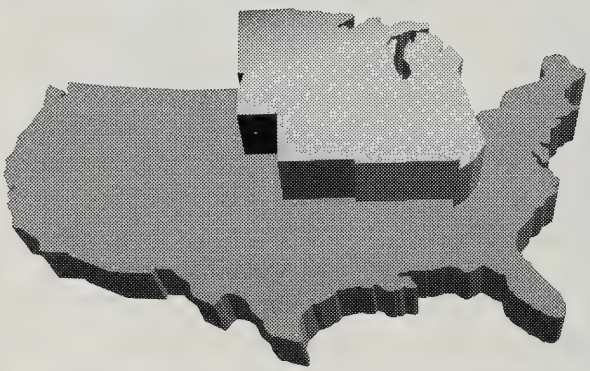
Since physicians may face liability or disciplinary action for inappropriate release of records, there are risk management factors to consider in hiring an outside service. (Remember, patients get angry if their records are mishandled!)

Here are some questions to ask before you hire an outside copy service:

- Does the copy service keep abreast of medical record law, including special rules for records regarding HIV, alcohol or substance abuse or mental health treatment?
- Are the service's policies compatible with your clinic's philosophy of service?
- Who will determine what is released?
- Does the copy service have safeguards to protect patient confidentiality?

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

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Newsmakers

Polk county president clarifies position on single Medicare locality

Dear Editor:

The Polk County Medical Society wishes to commend the IMS for its redesign of *Iowa Medicine, Journal of the Iowa Medical Society*.

We were pleased to see a medical economics section. However, in reading about a single Medicare locality, we noticed that the only comment about Polk County opposition was because of reimbursement reductions. In part that was correct, but there were other key factors not listed in the article which we believe our decisions were based on.

Letter to the Editor

The Polk County Medical Society is concerned that the total dollars coming into Iowa under a single payment system would be lower. HCFA could not guarantee physicians the change would be budget neutral. Since Iowa is already 48th in reimbursement among the 50 states, we did not want the reimbursement level to become even lower.

We believe that Iowa should become part of a regional designation which would bring the total dollars into Iowa at a much higher rate than today. To that end we have met several times with the Congressional delegation in Washington D.C. to discuss how this might be accomplished.

We are also concerned about the rural physicians and their ability to recruit other physicians. We would like to work together with all the physicians in the state for a more equitable payment system.

Together let's work toward bringing Iowa's Medicare reimbursement in line with the other midwestern states.—*B. Chandramouli, MD, president, Polk County Medical Society, Des Moines.*

Awards, appointments, etc.

Dr. Stephen Wolf of Pediatric Surgical Associates, Des Moines, has written an article which was published in the fall issue of the *Iowa Perinatal Newsletter*. The article is entitled "Risks of Surgery." **Dr. Larry Otteman,** McFarland Clinic, Ames, has been named to the board of directors of the Iowa Oncology Society. The Iowa Association of Long Term Care Facilities Medical Directors has named its 1994 officers: **Dr. Ronald Roth,** Waterloo, president; **Dr. Emmett Mathiasen,** Council Bluffs, past president; **Dr. Roy Overton,** II, Des Moines, vice president; **Dr. Dean Bunting,** Davenport, secretary/treasurer; **Dr. Paul Ferguson,** Lake City; **Dr. Clifford Rask,** Maquoketa; **Dr. Gerald Jogerst,** Iowa City, board members. **Dr. N.K. Pandeya,** Des Moines, has been awarded fellowship in the Association of Surgeons of India. **Dr. Thomas Schryver** has joined Sioux City Family Physicians. **Dr. Bruce Miller** has joined Cardiovascular Associates, Sioux City. **Dr. Delwyn Lassen** has joined the Siouxland Family Practice Center in Sioux Center. The Iowa Society of Rehabilitation Medicine has named its 1994 board of directors: **Dr. Buddy Nichols,** Cedar Rapids, president; **Dr. William DeGravelles, Jr.,** Des Moines, past president; **Dr. Marvin Hurd,** West Des Moines, vice president; **Dr. Fareeduddin Ahmed,** Davenport, secretary/treasurer; **Dr. Paulette Lynn,** Dubuque, representative to the American Academy of Physicial Medicine and Rehabilitation; **Dr. W.H. Verduyn,** Waterloo, board member. **Dr. Timothy Walsh** has joined Dodge Street Anesthesiology in Dubuque. **Dr. Scott Meyer** of the Iowa Orthopaedic Center, Des Moines, has written an article which was published in *Clinics in Sports Medicine,* volume 12, #4. The article is entitled "Stress Factors of the Foot and Leg." The Iowa Medical Group Management Association has named its 1994 executive council: **Dick Clock,** OB & GYN Associates, Des Moines, president; **Karin George,** Surgery PC, Des Moines, past president; **Alice**

AT A GLANCE

Doctors' Day is March 30. This day is set aside to recognize the role physicians play in caring for the sick, advancing medical knowledge and promoting improved public health.

***Laverne Wintermeyer, MD,** state epidemiologist, reports hantavirus has been found in blood collected from Iowa mice. In a study of Lyme disease, Iowa State University tested 150 mice for hantavirus antibodies. Thirteen mice (8.7%) were positive. Cases of hantavirus infection in humans have been found in Kansas and North Dakota. For more information contact Dr. Wintermeyer at 515/281-5787.*

Newsmakers

continued

Eveleth, Esterville Medical Center, PC, vice president; **Nancy Park**, Marshalltown Medical Clinic, secretary; **Steven Hilpipre**, Spencer Medical Associates, treasurer; **Denise Chaffee**, Family Practice Center, Cedar Rapids; **Richard Golly**, Eye Surgeons Associates, PC, Davenport; **David Linder**, McCrary-Rost Clinic, PC, Lake City; **Sue Marsh**, Atlantic Medical Center; **Randy Samuelson**, Cardiovascular Associates, Sioux City; **Joy Willis**, OB & GYN Specialists, PC, Davenport, board of directors.

IMS Annual Scientific Session and House of Delegates will be held at the Savery Hotel in Des Moines April 15-17.

New members (as of November 1993)

Altoona
Edmund Eisnaugle, DO, family practice

Bettendorf
Randall Bay, MD, emergency medicine

Carroll
Theodore Liautaud, DO, psychiatry

Cedar Falls
Robert Leverence, MD, pediatrics

Cedar Rapids
Andrew Barden, MD, pediatrics/neonatology
John Bennett, MD, resident
Timothy Brinkman, MD, resident
Paul Floy, MD, resident
George Ho, Jr., MD, rheumatology
Clint Kauffman, MD, resident
Walter Larson, MD, pediatrics
Timothy Martin, MD, cardiology
Ann Metzger, MD, resident
Sonia Sather, MD, resident
Amitagh Shrivastava, MD, pediatrics
Catherine Sutera, MD, resident
Catherine Zavala, MD, resident

Cherokee
Donald Gebers, DO, internal medicine

Davenport
Paul Brown, MD, family practice
Darryl Johnson, DO, obstetrics
Siv Saetre, MD, ophthalmology
James Wymore, MD, ophthalmology

Decorah
Karen Cowan, MD, family practice

Des Moines
Bradley Adams, DO, orthopaedic surgery
Paula Mahone, MD, maternal fetal medicine
Nadeen Wyndham-Omar, MD, resident

Dubuque
Gary Bernard, DO, family practice
Bethann Bonner, MD, pediatrics
Debbie Cihak, MD, internal medicine
Warren Gall, MD, cardiovascular & thoracic surgery
Kleven Israelsen, DO, family practice
Andre Langlois, MD, radiology
Judson Ott, MD, orthopedic sports medicine/traumatology
Ronald Ramstedt, MD, general & vascular surgery
Prasad Yalavarthi, MD, oncology

Eldora
Louis Harrell, DO, family practice
Young Park, DO, family practice

Fort Madison
Carl Makarewicz, MD, radiology

Iowa City
Robert Herting, Jr., MD, resident
Todd Hlavaty, MD, resident
Glenn Kolansky, MD, dermatology
Kerry Mattingly, MD, resident
Bruce Monson, MD, radiology
Michael Muhonen, MD, neurosurgery
Bartholomew Sak, MD, resident
Annette Schleeter, MD, resident
Stephan Schomer, MD, cardiology
Joel Sorosky, MD, obstetrics/gynecology

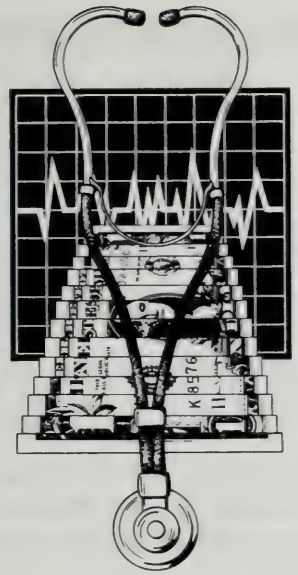
Marshalltown
Douglas Cooper, MD, orthopaedic surgery

Mason City
Allison Faches, MD, resident
Victor Henderson, MD, radiation oncology
Alan Hjelle, MD, resident
Paul Manternach, MD, resident
Brian Scott, MD, resident
Todd Treimer, DO, resident

Ottumwa
Steven Quackenbush, MD, clinical & anatomic pathology

Sioux City
Calvin Andersen, MD, radiology
Michael Chandra, MD, internal medicine & cardiology
David Daniels, MD, internal medicine/geriatrics
Charles Flohr, MD, radiology
Garry Greenfield, MD, orthopaedic surgery
Kevin Hamburger, MD, obstetrics/gynecology
Mark Haslett, MD, child & adolescent psychiatry
Lorraine Hazard, MD, family practice
Stephen Kahanic, MD, medical oncology/hematology IM

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Violence as a Public Health Issue — Breaking through the Barriers to Prevention

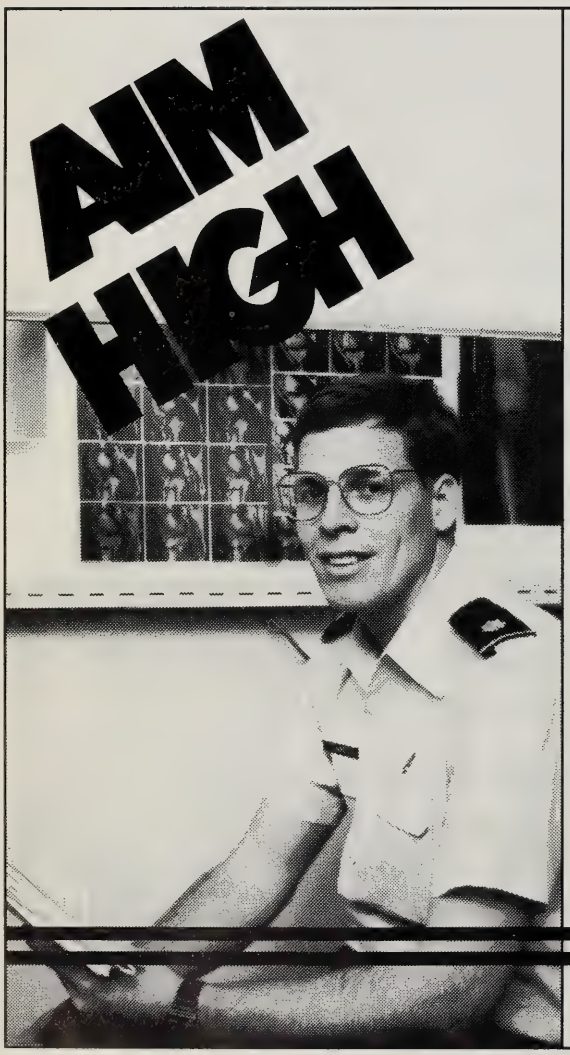
Guest speaker: Dr. Beverly Coleman-Miller of Washington, DC

Saturday, March 12 ● 7:00 p.m.
Van Allen Hall
Lecture Room 1
University of Iowa Campus

"When we see images of discrimination or death in Bosnia or Somalia, the U.S. rushes to help. Yet, there's a chronic, undeclared war taking place in our own cities...a war which needs the same attention and resources."

Dr. Coleman-Miller made this comment during a recent National Press Club news conference on urban violence. Dr. Coleman-Miller is president of the National Council for International Health and is a leading authority on the impact of community, social and environmental issues on public health. She served as special assistant for medical affairs to the D.C. Commissioner of Public Health.

All Iowa physicians are invited to attend this eye-opening, inspirational lecture.
This event is sponsored by the Student Medical Society at the UI College of Medicine.



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Is PATIENT SATISFACTION *YOUR* OFFICE TEAM'S GOAL?

As competition for patients increases, patient satisfaction will become more and more crucial for your practice. Are you in this necessary game or watching from the sidelines? A key success factor is recognizing that every member of your office team is important in creating satisfied patients.



Like it or not, competition for patients has become a practice reality. In metropolitan areas where managed health care and insurance carrier activity is intense, there is an increasing reliance on patient satisfaction as a key determining factor in whether a physician provider becomes or remains a member of a panel.

For example, this has happened in Iowa with patient satisfaction surveys conducted by Blue Cross and Blue Shield of Iowa among members of its Blue Advantage Network. Surveys of over 35,000 patients of the providers on this panel were conducted in 1993. The survey response was excellent, with 45% (16,025) patients returning the completed surveys.

The survey examined patient satisfaction with access to care, personal concern of the physician and staff, organization of the physician office, communications, attitudes toward care and outcomes of care.

The Blues have communicated their intent to include the level of patient satisfaction in determining their future relationship with panel members. This may affect the level of compensation for services as well as the panel membership.

Physicians may have difficulty recognizing patient satisfaction must be consciously gained.

Warm, fuzzy vs. cool, mechanical

To say the practice of medicine has been changing over the past few years elevates understatement to high art. We know progress in the clinical sciences has been particularly significant, but the evolution of the business of medicine has been at least as dramatic. What was once a warm and personal relationship between doctors and patients is often supplanted by a cooler, more mechanical interplay as physicians are pressured by carriers and health plans, monitored by PROs, questioned by quality assurance committees, directed by clinical outcomes studies and faced with patients who have growing expectations.

There are many reasons why we now focus on patient satisfaction rather than taking it for granted. In medical offices today, achieving patient satisfaction should be viewed as a goal to be consciously gained rather than a natural consequence of a physician-patient encounter.

William Walsh
Mr. Walsh is a principalin the firm of Walsh & Walsh Consultants of Scottsdale, Arizona. He is a nationally-recognized expert on marketing.

Because of a difference in perception, physicians may have difficulty recognizing patient satisfaction as something to be consciously attained. Any discussion of the quality of health care must take into account that doctors and patients don't usually share the same ideas of what constitutes quality care.

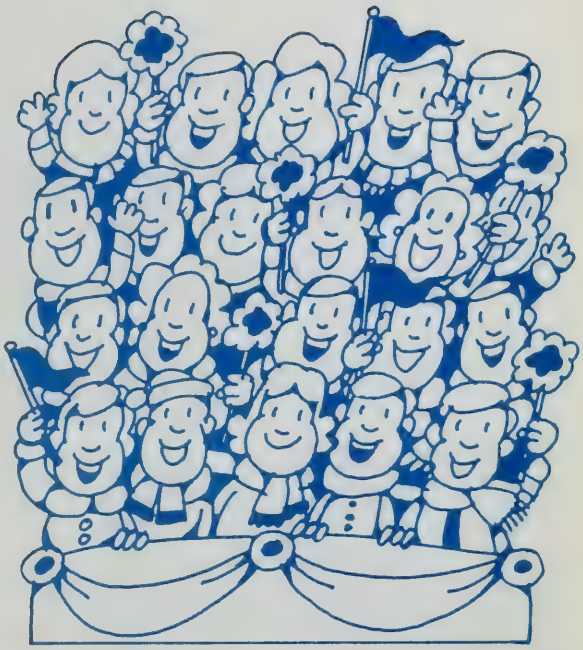
A physician will usually define quality in terms of the clinical outcome of care, but the patient typically regards quality as the sum total of all experiences with a practice. Patients do not usually have enough sophistication to judge clinical quality. Whether a patient is satisfied with the care received will be determined from the first moment a call is placed to the practice to ask for an appointment.

Public image is crucial

A physician's ability to assure patient satisfaction is becoming more critical as medical practice becomes more competitive. The marketplace conditions cited in the beginning of the article are compounded by the growing competition for patients. This may take place because of the influence of managed care plans in a given location, or by a growing number of physicians for an essentially static population.

Regardless of the exact conditions, all physicians should understand that patient satisfaction is almost certain to have a serious impact on every practice's bottom line in the not-so-distant future.

Although the comparison may sound far fetched, there is a great deal of similarity between the business side of a medical practice and the airlines. Both are service industries dependent on public image for differentiation among providers. The pilot is the captain of the aircraft just as the physician is the captain of the medical team providing patient care. Both have staffs who assist the principals in charge of providing the services. Airlines have ticket agents, baggage handlers and flight attendants; medical practices have receptionists, x-ray technicians and nurses.



With the help of your office team, your patients will become your most loyal supporters.

In each business, the customer/patient will usually spend more time relating to staff members than to the principals in each business. If we track the patient from the time of the first telephone call through the actual visit, we will see that the patient relates to at least two or three staff members in addition to the physician. A physician skilled in handling the clinical and psychological needs of the patient may not be able to overcome the negative effects if the staff does not also fulfill the expectations of the patient.

Patients may not express dissatisfaction

The consequences of a dissatisfied patient are as serious to a medical practice as they are to any other business. Many physicians are dependent on patient referrals as the source of future patients.

In fact, studies show that favorable word of mouth will have a greater impact than advertising and public relations, particularly for primary care physicians.

Findings in a study conducted by the Technical Assistance Research Programs Institute on behalf of the U.S. Office of Consumer Affairs substantiate how important patient satisfaction can be to a practice.

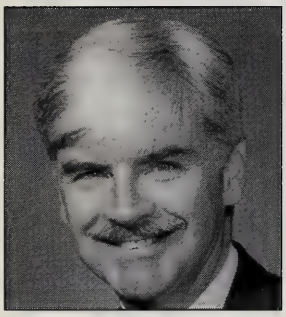
The findings show that:

•For every complainer there are 24 others with the same complaint who will never say anything.

•Thirteen percent of all dissatisfied customers will each tell 20 people about their unhappy experience.

Clearly, physicians relying on their intuitive knowledge of patient satisfaction may not see the complete picture. Many patients feel their relationship with their doctor may be a life and death matter.

As a result, patients are probably even less likely than other consumers to voice their dissatisfaction directly to their physician.



William Walsh provides professional services marketing and is a nationally-recognized innovator in strategic business planning, marketing and managed health care relations for physician practices all over the country. He has been a presenter at several seminars sponsored by IMS Services.

Patients hold you responsible

Any attempt to increase patient satisfaction must begin with the physician, who is the person patients hold responsible for the quality of their care. Physicians must provide leadership by example to all staff members. A careful evaluation of whether the practice is patient-oriented or physician-oriented should be conducted.

A patient-oriented practice makes every effort to accommodate the medical, social and psychological needs of a patient. It recognizes the patient as a consumer who has many choices in the medical marketplace. A patient-oriented practice is more inclined to have extended hours in consideration of patients' work schedules. Patient-oriented practices make deliberate attempts to minimize waiting time by realistic scheduling.

A key element in creating a patient-oriented practice is your practice's hiring process. Obviously, it is very important to attract technically competent staff members, but an equal emphasis should be placed on the candidate's ability to relate to people in a warm and accommodating manner. Technical skill is difficult for patients to recognize but a warm and caring personality is obvious to everyone.

Equal importance should be placed on the ability to relate to people in a warm manner.

Physicians and staff should not simply react to patient concerns. They must anticipate needs and see clues when these needs are not being met. If a patient returns to the reception desk to ask how much longer it will be before they see the doctor, the staff should recognize this as a sign of dissatisfaction.

Empathy, immediately expressed in the face of such an incident, can diffuse many patient grievances. There will seldom be a case when a provider can win over a patient by arguing the merits of their complaint.

Staff members should appreciate the fact that the patient is unhappy and offer an understanding ear. It is important to assure patients that the incident is not typical of the practice's high standard of service. That reassurance should be grounded in fact.

Conduct patient surveys

Periodic patient surveys are a good way to assess the level of satisfaction. These can be done by professional research services or by the practice itself through printed

questionnaires. (See the box below for tips on conducting patient satisfaction surveys.)

However, experience has shown that conducting such surveys increases the expectations of the patients. If a practice conducts a survey and discovers significant areas of dissatisfaction but does nothing to correct them, patients will believe the physician lacks sincerity.

As patients become more particular in their choice of providers, competition for patients becomes more critical to the bottom line. Thus, the question of patient satisfaction must receive even greater emphasis. The cost of ignoring the satisfaction level of your patients may be higher than you think. IM

More on patient satisfaction surveys

If you have never conducted a survey to measure satisfaction among your patients, there is one key factor to keep in mind: writing such a survey is not as easy as you might think. In fact, a survey that is poorly-worded or unprofessional in appearance may not elicit the information you want, may elicit misleading information and could even be harmful to your practice image.

One good idea is to solicit samples of surveys from clinics or group practices. One expert believes every patient survey should ask "Would you want to see this physician in the future? Why or why not?"

IMS staff can advise you on creating a patient satisfaction survey. Contact Barb Cannon at 515/223-1401 or 800/747-3070.

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The Journal
of the Iowa Medical Society

Medical symptoms of psychiatric illness

● *William Yates, MD*

Many psychiatric illnesses produce significant physical symptoms. Patients often interpret these symptoms as indication of a medical illness and seek help from their primary care physicians. Frustration is often the result when physicians are unable to find a physical cause for the patient's physical symptoms. Both the physician and the patient are unsatisfied with the outcome. The patient continues to suffer and the physician is unable to find a medical treatment which reduces the patient's distress.

Extending the differential diagnosis of physical symptoms to psychiatric disorders helps the physician accurately diagnose and treat many patients. There are opportunities and problems for physicians in managing patients with unexplained physical symptoms.

Patients resist referral

Psychiatric disorders are common in primary care populations.[1] The primary care physician has often established a strong patient-physician relationship which promotes open communication and compliance with physician recommendations. Accurate diagnosis and treatment can improve management and significantly reduce the cost of care. Successful treatment now available for many psychiatric illnesses can produce decreased patient distress and decreased health care utilization.

Also, diagnosis and treatment of psychiatric disorders in the primary care office setting can reduce or limit the stigma associated with psychiatric disorders. Many patients resist referral for psychiatric consultation. The primary care physician may be the only caretaker with the opportunity to accurately diagnose and treat psychatric disorders for many patients.

Advances in diagnostic precision have also provided an opportunity for primary care physicians.[2] Psychiatric diagnosis has become more oriented to a medical model scheme. Psychiatric diagnosis is accomplished by inclusion rather than exclusion of medical disorder. Diagnostic criteria are available with increased reliability and validity. Many psychatric disorders have been found to be similar to medical disorders, in other words, they have a genetic component with biological mechanisms responding to medication management.

However, there are significant problems in management of psychiatric illness in the primary care setting. Many medical illnesses also produce symptoms found in psychiatric illness. For example the fatigue, sleep and appetite changes and concentration difficulties found in major depression can be produced by severe cardiac or pulmonary disease. Many primary care physicians have limited training in psychatric diagnosis and treatment. Some primary care physicians have limited interest in extending their area of expertise to mental disorders. Finally, the patient most often presents with a somatic complaint and may be resistant to a psychiatric diagnosis. Despite these limitations, now is an exciting time for collaboration between psychiatrists and primary care physicians in the psychiatric aspects of primary care.

Many times physicians are confronted with diagnostic problems that could be due to a psychiatric or a medical disorder. Information obtained in the history, review of systems, physical examination and laboratory are helpful cues to differentiate medical from

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for March 1994.

William Yates, MD
Dr. Yates is associate professor of psychiatry at the University of Iowa College of Medicine.

Medical symptoms of psychiatric illness

continued

TABLE 1
PRESENTATION FINDINGS FAVORING A MEDICAL VERSUS A PSYCHIATRIC ILLNESS

Medical illness	*Psychiatric illness*
Single physical complaint	Multiple physical complaints
Abnormal physical exam or lab finding	Normal exam and laboratory results
Negative personal history of mental illness	Positive personal history of mental illness
Negative family history of mental illness	Positive family history of mental illness
No major family or job difficulties	Difficulties in family and in work
Seeing a single physician	Seeing multiple physicians

psychiatric disorders (Table 1). Using elements of the history, physical examination and response to treatment, physicians can determine the risk of a medical or a psychiatric disorder. However, it is important to remember medical and psychiatric disorders may coexist in patients. Physicians should not fall into the trap of ignoring all medical symptoms in psychiatric patients or to attributing all psychiatric symptoms to an underlying medical condition.

Although historical and physical findings may raise the likelihood of a medical or psychiatric disorder, these risk factors are not infallible. Careful consideration of psychiatric disorders should also be routine in screening and diagnostic evaluations.

Psychiatric disorders with physical symptoms

Although there are over 250 diagnoses in DSM-III-R, the number applicable to most primary care physicians probably numbers less than thirty.[2] When there are no apparent medical causes for a patient's physical symptoms, a brief psychiatric differential diagnosis can be considered (Table 2).

Mood disorders, especially major depression and dysthymia, are common psychiatric disorders in primary care. The high rates of prevalence for mood disorders in primary care have been documented in many studies. Since mood disorders often include physical symptoms such as fatigue and sleep disturbance, these symptoms may be the focus of physical attention. Mood disorders can also occur after severe and chronic medical illness. In this situation, the depression is secondary to medical illness. Depression secondary to medical illness requires attention to control of the medical illness as well as evaluation and treatment of the mood disorder.

Case example: Neil G. is a 69-year-old married man with chronic pulmonary disease who reports increased fatigue. Over the last year, his COPD has progressed, resulting in decreased mobility, 24 hour oxygen therapy and decreased independence. He is also experiencing slowed thinking, reduced concentration and memory deficits. He has a family history of alcoholism and a previous personal history of alcohol abuse. He had a previous episode of depression requiring contact with a counselor. Mr. G. has become self critical and hopeless about the future. He frequently thinks about death and wonders if suicide is the best option available given his medical condition.

Severe physical illness does not preclude the presence of a depressive disorder. It might seem reasonable to feel depressed about a chronic medical condition, but concurrent depression can significantly increase distress and suffering. Aggressive treatment for depression can limit the disability associated with chronic medical conditions.

Anxiety disorders

Anxiety disorders also frequently produce physical symptoms along with visits to primary care physicians. Anxiety disorders can produce a variety of physical symptoms such as chronic headache, abdominal pain, diarrhea, palpitation, fatigue and sleep disturbances.[3] Patients often are anxious about physical symptoms and display somatic and hypochodriacal concern. Treatment of the anxiety disorder can result in improvement in these somatic symptoms.[4]

TABLE 2
PSYCHIATRIC DIFFERENTIAL DIAGNOSIS FOR UNEXPLAINED PHYSICAL SYMPTOMS

Mood disorders
Major depression
Dysthymia
Anxiety disorders
Generalized anxiety disorders
Panic disorder
Somatoform disorders
Somatization disorder
Hypochondriasis
Adjustment disorder with physical complaints
Personality disorder
Alcohol and drug dependence

Case example: Anna B. is a 30-year-old woman admitted for acute chest pain. Overnight monitoring, electrocardiogram and graded exercise treadmill are normal. She reports her chest pain is accompanied by palpitations, dizziness, tachycardia and intense feelings of doom. The spells occur spontaneously and are not precipitated by exertion. Ms B. has a history of being a nervous individual and has a sister who has been treated for depression. She has experienced the spells at least once a week over the last 2 months. Ms B. avoids grocery stores and crowded malls, fearing she will have a spell and be unable to get help.

Atypical chest pain in young women is a frequent presentation for panic disorder in primary care. Panic attacks are often spontaneous and interpreted as symptoms of a heart attack or breathing problem. Patients often describe their symptoms as severe and dramatic, producing attempts to avoid any situation that might produce an attack. Long-term panic disorder can result in patients becoming housebound from fear of having an attack (agoraphobia).

Somatoform disorders

Somatoform disorders is a group of psychiatric illnesses with a predominant picture of physical symptoms without physical illness. After ruling out medical causes, physicians may feel enough has been done for the patient. However, for the patient the symptoms remain and they remind the patient that something may be medically wrong. This can motivate them to see other physicians until a cause is found. Additional medical testing and even surgical intervention may occur, resulting in morbidity and increased health care expenditure. Successful management strategies for these disorders exist and have been found to significantly reduce the utilization of health care services.

Case example: Geneva N. is a 45-year-old married woman presenting for a second opinion. She has multiple somatic complaints and states she has been "sickly" most of her life. She reports fatigue, headaches, abdominal pain and menopausal symptoms. She has a personal history of psychiatric care and several family members with alcoholism. Multiple drug allergies are reported. Her regular physician reports multiple physician contacts. Review of screening symptoms for somatization disorder reveals positive responses to all.

Although the primary care physician is often aware if their own patients have somatization disorder, new physician contacts may not have a complete patient history. Screening for somatization is important in patients with multiple unexplained somatic complaints, particularly if they have seen several physicians.

Hypochondriasis is another somatoform disorder. In contrast to somatization disorder, hypochondriasis is often limited to a single physical complaint or a preoccupation that a specific physical illness is present. A continuing fear of cancer despite extensive medical evidence to the contrary is typical.

Adjustment disorders, personality disorders and alcohol and drug dependence can also be associated with physical symptoms without evidence of a physical illness. Severe stress can produce physical symptoms as well as mood and anxiety symptoms which result in the diagnosis of an adjustment disorder. Personality disorders and the substance use disorders also produce unexplained medical symptoms. These psychiatric illnesses also deserve consideration when unexplained medical complaints persist.

A psychiatric differential diagnosis may be beneficial for patients who have unexplained medical symptoms.

References

References are available from the author or the editors of *Iowa Medicine*. IM

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Let's eliminate the weeds

Many of my friends and colleagues share my interest in gardening. At this writing, the temperature outdoors is below zero. The ground is covered with ice and snow. Yet, last week my enthusiasm for gardening was rejuvenated by a visit to a commercial greenhouse.

Yes, in the poor man's garden grow
Far more than herbs and flowers —
Kind thoughts, contentment, peace of mind,
And joy for weary hours.

Mary Howitt (1799-1888)
The Poor Man's Garden

As many of my readers know, during the growing season I serve as the volunteer gardener for the Victorian Mansion at the Living History Farms near Des Moines. Now is the time of year to order the plants for the coming season . . . that was my mission of pleasure at the greenhouse.

What has this to do with a medical journal? The life of a physician should not be devoted entirely to medicine. Some professionals devote most of their waking hours to their calling, and this is most unfortunate. Diverse interests make life fulfilling. In a recent editorial, I alluded to a difference between education and training. In a similar vein, I equate gardening with a form of training.

To establish a garden requires planning, cultivating and nurturing. The crop can be enhanced by efforts beyond mere preparation and planting. Loving care, enhancement of the growing environment and elimination or prevention of unwanted growth (weeds).

Our well-being is affected by numerous social problems. Crime, violence, homelessness, substance abuse and pregnancies among unmarried teenagers are only a few of the many social ills that pervade our lives. These problems are "weeds" of civilization that invade what could be the beautiful and productive garden of life.

We in the medical profession hold a unique position and opportunity to cultivate a more joyful garden of life. As we serve our patients and their families, we have a responsibility to work as good citizens to make our society less dominated by the weeds of undesirable actions by those who need guidance and cultivation toward a better way.

These problems are 'weeds' of civilization that invade what could be a beautiful garden.

Become involved in civic efforts, let our lawmakers know of your concerns and set good examples for all of society. Be a gardener of life and you too can have "kind thoughts, contentment, peace of mind and joy for weary hours." IM



MARION ALBERTS, MD

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8:00	Opening remarks
8:15	New ideas on an old arrhythmia - Atrial Fibrillation
9:00	Syncope
9:45	BREAK
10:00	Coronary revascularization using arterial conduits
10:45	Cardiac evaluation of the parient undergoing non-cardiac surgery
11:30	Question session
12:00	Lunch
1:00	Current therapy for carotid artery disease; Medical and surgical approaches
2:00	Questions
2:15	BREAK

Concurrent Workshops

2:30	Auscultation of the heart - media presentation Pediatric Cardiology GUSTO
3:15	BREAK
3:30	Auscultation of the heart - media presentation Management of common arrhythmias Medical case studies
4:15	Evaluations

Getting into medical school

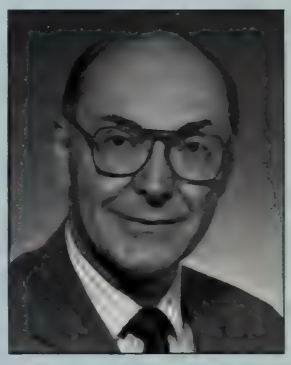
Have you heard it said, or maybe even said it yourself, perhaps in an angry, distressed tone of voice: "The only way to get into medical school these days is to have top grades and admission test scores — nothing else makes a difference." If you thought you were speaking of the University of Iowa medical school, I'm delighted to say you're wrong. About other medical schools I can't say, but having just finished a three-year stint on our admissions committee, I believe I'm in some contact with the reality and am willing to tell you about it.

Oh yes, overall grades do matter and so do the scores on the national admission test. I won't deny that. And they should matter, but there are lots of other considerations. Using only those two variables would be analogous to making a diagnosis of heart failure upon being told a patient had dyspnea and a respiratory rate of 36 per minute — you'd insist on more data. And so does the admissions committee. It really has lots of data about our applicants and I firmly believe our 15 voting members read that information and weigh it in reaching their decisions about each candidate.

If you were a committee member, I doubt that you'd seek to admit candidates of low academic achievement simply because their performance had been meager. True, Einstein as a young man was denied admission to a school because his record wasn't sufficiently stellar. But would you therefore admit an entire medical school class from the low end of the academic barrel because it might include one budding Einstein? Come on, get real! Wouldn't you and your committee colleagues acknowledge a difference between grades attained at Harvard versus those attained at East Overshoe College? Of course you would and the standardized test scores are particularly helpful in guiding that assessment.

But, you may still protest, what about moral character, trend-over-time in grades, non-science grades, number and difficulty of courses, the personal statement, extra-curricular activities, volunteer or paid work, interest in primary care medicine, participation in health care or research, rural/urban background and other life experiences? What of responses on the 20-variable form (plus open-ended remarks) completed by three persons well known to the applicant and chosen by that person to offer assessment. Yes, these and still other data are in the file and in the committee members' minds as they decide their vote on an applicant. Surely, you may yet protest, there must be a way to tell which of these applicants will be a "good doctor" (presuming we can agree what that means) and admit no other kind. Surely there must be some technique — rational, reproducible, reasonable — that can do this selecting. Sorry, folks. There are helpful indicators, but the process is loaded with subjectivity and depends on one's values. In that sense, when you get down to it, it's just like the practice of medicine. IM

Sorry, folks. The process is loaded with subjectivity and depends on one's values.



Richard Caplan, MD

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Family Practice Physicians—Gundersen Clinic is a 300-member multispecialty group practice which is adjacent to Lutheran Hospital, La Crosse, Wisconsin, a 402-bed tertiary care facility. As a result of our continued growth and a 100-year tradition of exceptional medical care, we are seeking family practice physicians with interest in routine obstetrics. Currently, we are recruiting family practice physicians to serve in our main La Crosse clinic, plus each of these branch clinics: 1) Gundersen Clinic, Decorah, Iowa; 2) Gundersen-Farrell Clinic, Prairie du Chien, Wisconsin; and 3) Gundersen-Mubarak Clinic, Tomah, Wisconsin. Our clinics provide specialized and primary care to nearly 70,000 families through over 745,000 visits per year. Our family practice group is the second largest department in the Gundersen system. Call groups vary in size depending on the community. The successful candidates will enjoy full administrative and technical support while being allowed to exercise your medical judgement without intervention. You will be encouraged to develop your practice based upon the needs of the community. In addition, we also offer extensive opportunities for continued education, and to perform clinical research. For more information, including salary and benefits, send your CV or call Tim Skinner toll-free 800/362-9567 or call collect 608/782-7300, ext. 6673. Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601. An equal opportunity employer.

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Primary care physicians needed—Community Health Care in Davenport, Iowa, is overwhelmed by demand and needs to add physicians to its current staff. In addition, expansion is on the horizon. We are searching for pediatricians, family practitioners and obstetricians. The group already includes those specialties plus an internist, several mid-level providers as well as a dental department. On-site facilities include lab, pharmacy and x-ray. The 2 local 250-bed hospitals are merging. Davenport isn't flooded any more; great schools and good recreational opportunities. Competitive salary/benefit package. Contact Rebecca Wiese, MD, Medical Director, 428 Western Avenue, Davenport, Iowa 52801; 319/322-7899, fax 319/322-4013.

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Regular classified advertising sells for $2.00 per line with a $30 minimum. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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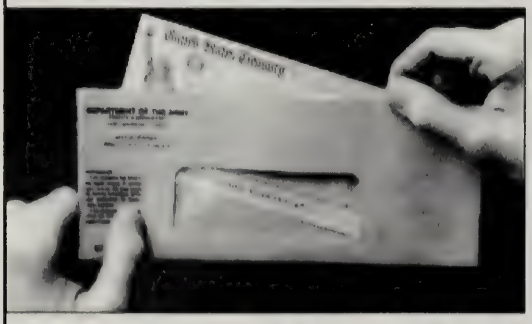
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One out of many

This month's *Iowa Medicine* features the University of Iowa College of Medicine. Both as patients and as physicians, we are fortunate to have their services available.

We have a world-class institution in Iowa City delivering a myriad of programs and services to Iowans. In addition to their role in undergraduate medical education, they serve Iowa as one of the largest tertiary care centers in the country. UI residencies and research programs are in great demand. Iowa physicians directly benefit in many ways. The staff at the UI help us with everything from curbside consultations, speakers and patient care to CME. When you contact your legislator, don't forget to ask that adequate funding continue for the UI College of Medicine and the UI Hospitals and Clinics.

Speaking of CME, in February IMS officers and trustees undertook political CME at the AMA National Leadership Conference in San Francisco. The theme was "Leadership for Medicine in Transition". We heard from Joycelyn Elders, the U.S. Attorney General; Ira Magaziner and a host of other good speakers. A speaker I found particularly interesting was Haynes Johnson, Pulitzer Prize winning columnist for the *Washington Post*. Mr. Johnson believes this is a critical time in America because we don't know where we're going. Every segment of society is being scrutinized and tested. Nothing is safe from reevaluation, including medicine. We have had major societal testing twice during the past 200 years . . . 15 years before the Civil War and the years between the Depression and WWII. The decisions were fairly simple during those times. It was either fight, surrender or jump out of a window.

For the past two years, Mr. Johnson has traveled America talking to everyone from presidents to prisoners asking how they feel about their jobs, their families and being an American. His findings are encouraging. He believes the answer to our problems will not come from Washington but lies in our communities. This is where we find strength, caring, concern, family values and responsibility. He believes in "E Pluribus Unum" — one out of many — but cautions that some countries such as Yugoslavia are using the phrase "out of one many."

The answer to our problems will not come from Washington, but from our communities.

Besides being tax time, April is also the time for our annual IMS Scientific Session and House of Delegates. Please join us in Des Moines April 15-17 at the Savery Hotel. A Forum on Health System Reform is planned on Saturday and we need as many viewpoints as possible during this discussion. Without input from Iowa physicians, we cannot confront this issue with our own E. Pluribus Unum.

I hope to see you all there. IM



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Now in its fourth year, Cardiology at the Bix, sponsored by St. Luke's Regional Heart Center has featured internationally acclaimed speakers, as well as attendees from all over the country. Held at the beautiful, historic Blawkhawk Hotel in Davenport, it draws internationally acclaimed physicians.

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More than 18,000 runners are expected for what Runner's World calls "the road race with the most community spirit." Scheduled for July 30, the Bix 7 is the eighth largest road race in the United States.

Faculty

THOMAS SHIMSHAK, M.D., Clinical Associate Professor of Medicine, University of Missouri, Kansas City, Missouri.

JONATHAN LANGBERG, M.D., Professor of Medicine, Director Electrophysiology Laboratory, Emory University Hospital, Atlanta Georgia.

NORA F. GOLDSCHLAGER, M.D., Professor of Clinical Medicine, UCSF, San Francisco, California.

LINDA JEAN CROUSE, M.D., F.A.C.C., Clinical Assistant Professor of Medicine, University of Missouri School of Medicine, Director of Echocardiac Lab and Director of Women's Cardiac Center, Mid-America Heart Institute, St. Luke's Hospital, Kansas City, Missouri.

ALLAN ROSS, M.D., Professor of Medicine and Director of Cardiac Services, George Washington University, Washington, DC.

STUART FINE, M.D., Clinical Instructor, University of Illinois College of Medicine, Chicago, Illinois.

Registration Information:

Registration Fee: $95 includes attendance at the symposium, two free tickets for the Friends of Bix' Cocktail Party, 2 complimentary tickets for the Riverboat Gambling Cruise and 2 entries in the Bix 7 Road Race.

Confirmation and details about entertainment options will be sent upon registration.
For further information, please contact Rebecca Gannon (319) 326-8115.

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Speak with one voice

DAVID HOLLEY, MD

Editors' Note

While not all physicians will agree with every statement made in this guest editorial, it remains an eloquent plea for unity among physicians during the ongoing health system reform debate. This President's Page editorial is reprinted from the February issue of *California Physician*. It is reprinted with permission from *California Physician*. Copyright ©1994.

As I listen to the national health system reform rhetoric, my heart grows heavy. Using politically correct language, political leaders are positioning themselves to appeal to broad constituency groups. Our profession, in the meantime, is splintered with different groups speaking from their own perspective, usually based on economic considerations.

AMA is pictured as waffling on its support for an employment-based system as the principal means to fund expanded coverage. Realistically, that is the only method of achieving universal coverage without creating a tax-based government-run program. In response the Administration trots out the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Society of Internal Medicine (ASIM) and other specialty groups and touts their support of the President's proposal. In each of those instances, only half the story is being told.

At the AMA interim meeting, in an action spearheaded by New York, Texas and Florida delegations, the House adopted policy to consider alternative methods to fund an expanded health delivery capacity.

Some of these states would have liked AMA to repeal its employer-mandate endorsement. Although that did not occur, perception became reality and as a result, I fear AMA's strategic position might have been weakened. The White House reaction to a more flexible funding policy would make it seem so.

Many physicians would prefer to see an individual mandate or health-IRA substitute for an employer mandate. Individual responsibility and initiative play well in the movies and U.S. history books, but certainly not in the political arena. Can you imagine a politician voting to require individual consumers to purchase health coverage or fund a health IRA?

If medicine advances ideas that are political suicide for politicians, we become irrelevant in the debate.

An example of how difficult such a vote would be recently occurred in New York City. Teachers with the Catholic diocese school system were asked to contribute $30 a month for health coverage that their employer previously paid in full. Instead, they went on strike and shut down the school system. Such is the power of benefits that become considered entitlements.

If medicine advances ideas that are political suicide for politicians to consider, we will become irrelevant in the debate. A move to flexibility in fashioning health reform financing is desirable, but we can't allow ourselves to be painted into a corner by advocating positions

continued

Dr. Holley is president of the California Medical Association. He practices radiation/oncology in Monterey, California

Guest editorial

continued

that are politically and practically irresponsible.

Where are ASIM, ACP and AAFP focusing in this debate? On the surface, they support universal coverage, a broad benefit plan and other areas that virtually all physicians endorse. Beneath the veneer, however, their support revolves around reform elements that would enhance their members' economic interests: more emphasis on primary care, gatekeepers and shifts in reimbursement emphasis.

Concerns expressed by these physician groups with the President's proposal never appear in the press or are buried so deeply no one reads them.

The concerns expressed by these physician groups regarding problems with the President's proposal — and there are many — never appear in the press or are buried so deeply in text that no one reads them. The media focus on the differences within the house of medicine.

It is understandable why an organization would support its members' economic interests. After all, members pay dues and expect to be represented. However, we have been down this road before. RBRVS was supposed to accomplish the same end but Congress, HCFA and the Office of Management and Budget made RBRVS into something it was not supposed to be: decision-making at a level at which we don't participate. Reasoned arguments aside, politics and deficit reduction prevail.

As another example, several years ago, radiologists thought they would make a deal with Congress and protect themselves from reform elements that were on the horizon. Their leadership is still trying to explain how the deal went wrong. We can't afford to repeat past mistakes.

Washington is the big league of politics. While there, legislators often seem to forget their roots, their constitutency. We are currently seeing how the game is played. AMA wore a "white hat" until the media painted it as opposed to President Clinton's health plan. Now the White House is attempting to put AMA in its place by putting white hats on other physician groups. Are we going to play musical hats or are we going to participate effectively as a profession in the evolving debate?

If we don't all wear the same uniform, our opponents won't know who we are and won't care. We will end up as a group of Little League teams playing against the World Series champs. Our patients, the profession and the country would all pay the price. We must forge a consensus and thereafter all speak with the same voice. IM

Teamwork achieves success . . . benefits of IMS membership

As a new physician or as an established practitioner, you may be a loner or an active member of an organized community of physicians. What is the best choice?

You may have a successful practice and render excellent medical care. Patients may respect and admire you. You may be a role model in your community. But without organizational ties, you are likely to become separated from the family of physicians. You could fall behind the times or develop a sense of isolation as key issues are decided without your input. You may feel outside agents are governing your professional life and that you are impotent to resist.

Approximately 4,000 Iowa physicians (82%) avoid this situation by joining their county medical societies and the Iowa Medical Society. IMS provides diverse benefits and services to its members, including an annual scientific session, insurance programs and practice management consultations.

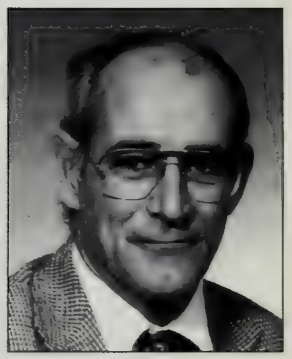
Perhaps the greatest benefit of IMS membership is the opportunity to leave the silent minority. Doctors do not always express their opinions but work around difficulties encountered in daily practice. We stood by as polls indicated a decreasing confidence in the medical profession. We have been reactive to the manipulations of politicians and lawyers. We have been shouldered, at least in part, with responsibility for the "health care crisis". We are perceived as a high income group which responds only to pocketbook issues. But, organized medicine is changing and will change further with input from new and younger members. Society must see our leadership in medical, political and economic arenas as positive. County medical societies and the IMS give us a forum and the leadership we need to achieve this goal.

Health system reform is a major political issue that will not disappear. Whatever plan emerges from Washington is sure to require fine-tuning. Major points under the public microscope are cost, access and quality. As patient advocates, we need to reverse the order of concern lest cost reduction efforts condemn the new plan to failure. Society cannot allow health care costs to spiral uncontrolled but reform should not be dictated by economists. IMS members can increase public awareness that quality cannot be sacrificed.

The greatest benefit of membership is the opportunity to leave the silent minority.

In the past, some issues of major significance may not have been addressed strongly enough by organized medicine. We need to be heard loudly regarding public health consequences of illicit drugs, smoking, teenage pregnancy, uncontrolled access to lethal weapons and a host of other social issues. If you question whether organized medicine represents your opinion, the answer is to participate and let your voice be heard. Whining in the background accomplishes nothing.

The vigorous pursuit of these goals requires participation. Active IMS members are the best recruiters of new members whose fresh perspective will make them our future leaders. IM



BERNARD FALLON, MD

Dr. Fallon is a professor of urology with the University of Iowa College of Medicine and president of the Johnson County Medical Society.

IMS Update

IMS House of Delegates weekend April 15-17

A **Forum on Health System Reform** will highlight this year's IMS House of Delegates and Scientific Session Friday-Sunday, April 15-17 at the Savery Hotel in Des Moines.

The Forum will be held at 10:30 a.m. Saturday following the opening session of the House. It will feature a panel discussion of plans proposed by various national specialty societies. Panel members are: Laine Dvorak, MD, president of the Iowa Academy of Family Physicians; Jerold Woodhead, MD, president of the American Academy of Pediatrics, Iowa Chapter; Steven Craig, MD, past president of the Iowa Clinical Society of Internal Medicine; and Luke Faber, MD, governor of the American College of Surgeons, Iowa Chapter.

Nancy Dickey, MD, AMA trustee, will discuss health system reform developments in Congress and William Eversmann, MD, a member of the Governor's Council on Health Reform, will discuss reform at the state level.

A question and answer period will follow the panel discussion. A luncheon will follow the **Forum on Health System Reform**. Any IMS member attending the Forum is welcome to attend the luncheon and the Reference Committees which follow. A tear-off Forum registration card was included with your March *Iowa Medicine*. You may also call Becky Bales or Linda Tideback at IMS headquarters, 515/223-1401 or 800/747-3070 to register.

The 1994 Scientific Session will begin on Friday, April 15. An MMIC risk management session will be held at 3:00 p.m. Saturday. The Scientific Session will conclude on Sunday morning with a presentation on primary care initiatives at the University of Iowa.

A reception for all IMS members attending the 1994 House of Delegates and Scientific Session will be held Friday evening from 5:00 - 10:00 p.m. at the Savery. The reception is hosted by IMPAC. The annual banquet and presentation of awards will be held Saturday, April 16 at 7:00 p.m. following the President's Reception. All IMS delegates should have received a delegate's handbook and other information in March. If you didn't receive yours, call IMS headquarters.

AT A GLANCE

Amid reports health system reform is dividing medicine, physicians have united to send a message to the White House and Congress. Every state medical society and 63 specialty societies have signed a letter stating that health system reform must ensure universal coverage and effectively control rising costs.

Health system reform was also on the agenda at a recent meeting between IMS leaders and representatives of the Iowa Hospital Association. Tort reform and fiber optics were also discussed.

The IMS will participate in a two-year study of the organized medicine federation structure spearheaded by the AMA.

Don Green, MD of Des Moines, has resigned from his position as IMS District Councilor after many years of service.

Policy resolutions cover key issues

Standards for expert witnesses and the definition of surgery are two of the subjects of Iowa Medical Society policy proposals received from Iowa physicians. As of press time, seven policy resolutions had been submitted for consideration at the 1994 House of Delegates April 16-17 at the Savery Hotel in Des Moines. The resolutions come from county medical societies and IMS Councilor Districts.

The following resolutions, listed in the order they were received, will be considered by IMS Reference Committees on Saturday, April 16 and by the House of Delegates on Sunday:

1. Expert Witness Standards *(Introduced by the Dubuque County Medical Society)*

Asks that the IMS support amending standards to require that expert witnesses in medical

Specialty Society Update

Because of the number of physician practices participating in their programs, Principal Mutual Group is now sending representatives to all meetings of the Iowa Medical Group Management Association Insurance-Reimbursement Committee.

The Iowa Psychiatric Society is spearheading a public affairs and legislative consortium of representatives of Iowa's state mental health providers and advisory groups. The purpose is to establish a statewide mental health campaign.

The Iowa Society of Anesthesiologists will hold its Spring Anesthesia Update Saturday, April 30 at the Embassy Suites Hotel in Des Moines.

Don Neumann, who recently retired as general manager of IMS Services, has been named the first honorary member of the Iowa Medical Group Management Association. Don was creator of the Administrator of the Year award.

Focus on IMS Alliance

Sharon Scott of Roseburg, Oregon, a representative of the AMA Alliance, will be the keynoter for the IMS Alliance Annual Meeting Friday and Saturday, April 15-16 at the Savery Hotel in Des Moines. Alliance members will join the IMS for a luncheon seminar on Friday. John Colloton, U of I vice president of statewide health services, will speak on health system reform.

Doug Howard of Iowa Welfare Reform will discuss the impact welfare reform could have on health reform at an IMS Alliance breakfast on Saturday.

Contributed by Judy Hoenk, IMSA president

liability cases be of the same specialty and discipline as the defendant physician.

2. Organ Donations *(Introduced by Councilor District IV)*

Asks that the IMS support legislation requiring operators of motorcycles and other recreational vehicles to sign a Universal Organ Donor card when they get an operator's license.

3. Single Medicare Payment Locality *(Introduced by Jasper County Medical Society)*

Due to "unfair differences in reimbursement" under the Medicare program, asks the IMS to do "everything in its power" to establish a statewide single Medicare payment locality in Iowa.

4. Group Health Coverage for Spouses *(Introduced by the Scott County Medical Society)*

Asks that the IMS "implore" Blue Cross Blue Shield to revise its policy so spouses and other covered dependents may continue their group insurance under the IMS member benefits program after the physician member reaches age 65 and applies for Medicare coverage.

5. Definition of Surgery *(Introduced by Councilor District III)*

Asks the IMS to adopt a policy that surgery be performed only by individuals licensed to practice medicine and surgery or by categories of practitioners specifically licensed by the state to perform surgical services and that the IMS call for legislation and rulemaking that defines what constitutes surgery.

6. Definition of Surgery *(Introduced by Siroos Shirazi, MD, delegate. Asks for essentially the same action as resolution 5)*

7. National Practitioner Data Bank *(Introduced by Pottawattamie-Mills County Medical Society)*

Asks that the IMS pursue all avenues to maintain confidentiality of information contained in the National Practitioner Data Bank.

Candidates for IMS offices named

The IMS Nominating Committee has assembled the following candidate slate for 1994-95 elections. The slate will be formally presented to the IMS House of Delegates on Saturday, April 16 and further nominations will be accepted from the floor of the House. The election will be held at the final House session Sunday morning.

Candidates for 1994-95 IMS offices

President-elect (1-year term)
Joseph Hall, MD, Des Moines

Vice-president (1-year term)
Siroos Shirazi, MD, Iowa City

Trustee (3-year term)
John Brinkman, MD, Mason City

Speaker, House of Delegates (1-year term)
Donald Kahle, MD, Dubuque

Vice Speaker, House of Delegates (1-year term)
Tom Throckmorton, MD, Spencer

AMA Delegates (2-year terms, 3 will be elected)
Clarence Denser, Jr., MD, Des Moines
Bruce Trimble, MD, Mason City
Donald Young, MD, Solon

AMA Alternate Delegate (2-year term)
Thomas Graham, MD, Iowa Falls

Councilor, District III
Eugene Kerns, MD, Davenport

Councilor, District VII
Steven Erickson, MD, Cedar Falls

Councilor, District VIII
Leo Milleman, MD, Ames

Councilor, District XII
John Fernandez, MD, Council Bluffs

Councilor, District XV
Kathryn Opheim, MD, Sioux City

Special Election, Councilor District X
Michael Disbro, MD, Des Moines
(Don Green, MD, Des Moines, has resigned. Two years remain of 3-year term.) IM

The resolution asks the IMS to do "everything in its power" to establish a statewide single Medicare payment locality.

Health System Reform

Show of unity from organized medicine

The Iowa Medical Society is one of 51 state medical societies signing a statement of unity on health system reform. The statement, which is also signed by 63 specialty societies, appeared in a full-page advertisement in several Washington, DC newspapers during the AMA's physician fly-in March 7-9.

The statement, which was sent to the White House and Congress reinforced medicine's firm stand behind basic beliefs. It also reiterates organized medicine support for universal coverage and liabilility reform.

Iowa physicians at AMA fly-in

Representatives of the Iowa Medical Society were among the 800 physicians participating in the AMA's March 7-9 Washington, DC fly-in.

The purpose of the event — billed as the **Partnership in Action: Uniting for America's Health** — was to show unity in the medical profession on health system reform and to speak with lawmakers.

The Iowa delegation included James White, MD, IMS president elect; Clarence Denser, Jr., MD, vice chairman of the IMS Legislative Committee and Jackson VerSteeg, MD, IMPAC chairman; Eldon Huston, IMS executive vice president; and Tim Gibson, IMS vice president of policy and programs.

Key members of Congress gave presentations at the summit, including Sen. John Chafee of the Senate Finance Committee and Rep. Jim McDermott, a member of the House Ways and Means Committee. The Iowa contingent also met privately with members of the Iowa congressional delegation and their staffs.

In conjunction with the event, the AMA ran full page ads in the *Washington Post*, the *New York Times*, the *Wall Street Journal* and *USA Today* to emphasize the unity of the medical profession in support of meaningful health system reform.

ACS single payer support clarified

An issue sure to be discussed at the Iowa Medical Society's **Forum on Health System Reform** April 16 is the American College of Surgeons (ACS) support of a single-payer system.

While testifying before the House Committee on Education and Labor, David Murray, MD, chairman of the ACS Board of Regents, said the ACS Regents believe "single payer approaches probably provide the best assurance that patients will be able to seek care from any doctor of their choice." The statement sent shock waves through the medical community.

The *Wall Street Journal* commented, "That a mainstream group of medical specialists would take such a position has been considered almost unimaginable, akin to the AMA embracing socialized medicine."

The ACS endorsement came after Rep. Jim McDermott (D-Washington), leading sponsor of a single payer bill in Congress, made a presentation to the ACS Board. McDermott was ecstatic at the ACS endorsement, commenting that he will "take the surgeons over the Round Table any time." (A reference to the Business Roundtable vote in support of market-based reform.) The White House, though not in support of a single payer system, reacted favorably to the surgeon's stance.

The day after Dr. Murray's testimony, the American College of Surgeons issued an official statement further clarifying the testimony. (Turn to page 153 for the complete statement.)

"Dr. Murray expressed the need to ensure Americans have an opportunity to obtain the

AT A GLANCE

IMS members are urged to attend the ***IMS Forum on Health System Reform*** *at 10:30 a.m. April 16 at the Savery Hotel, Des Moines. For more details on the* ***Forum*** *and the IMS House of Delegates meeting, check the* IMS Update *section of this issue.*

The League of Women Voters plans to launch a national advertising campaign to inform Americans about key issues in health system reform. The campaign will include television and newspaper ads featuring a toll-free information number.

Kiplinger Newsletter *predicts Congress will pass a scaled-down health reform bill in 1994 and that whatever passes will be hailed as only the first installment. He predicts employer mandates won't be junked because "someone has to foot the bill."*

Rep. Pete Stark (D-CA) reportedly said that he'd "rather throw up than vote for the Cooper plan."

WORTH REPEATING

"America spends twice as much per student on higher education than the average for 24 industrial nations. Yet, how many professors endorsing global budgets to limit health care spending would favor capping professors' salaries?"

Goerge Will, in a *Newsweek* column entitled "The Clintons' Lethal Paternalism".

high quality health care services they need," read the statement. "He made it clear that the College has not endorsed any of the health care reform plans being considered by Congress."

ACS Director Paul Ebert, MD, said the surgeons "feel strongly about patient access to high quality surgical services and the Fellows of the College want to focus on that issue."

In the wake of the surprise testimony from the ACS, the AMA issued a statement on single payer systems. The statement came from Robert McAfee, MD, AMA president-elect and surgeon.

"The AMA believes the best interests of our patients are not served by putting medical decisions in the hands of faceless government bureaucrats and MBAs."

IOMA supports single payer system

The Iowa Osteopathic Medical Association Board of Trustees has voted to support a single payer health care system, but not a Canadian type system, according to Norm Pawlewski, IOMA's executive director. Pawlewski says the IOMA Board generally believes the current system "works well for most people" and that wholesale reform of the health care delivery system is not needed.

"We would be happy with insurance reform which guarantees coverage and portability and administrative reform to cut paperwork. However, if there must be wholesale reform, the IOMA Board believes a single payer system is the only way to achieve universal coverage without increasing taxes or reducing services," Pawkewski explains.

The IOMA Board voted unanimously in support of a single payer system, but they believe it should be administered by an independent board rather than by the government. This would save enough in administrative costs to ensure universal coverage, Pawlewski says.

There is concern among DOs that managed care will provide too many opportunities for what Pawlewski calls "lock-out of independent physicians" and that managed care will force doctors to become employees of large entities.

IMS position on employer mandates

The IMS Executive Council and the IMS Board of Trustees have both approved a policy stating support for "a broad range of strategies, including individually mandated insurance, mandated employer conduit, employer mandated insurance or establishment of Health Care Savings Accounts, as acceptable alternatives to accomplish universal health insurance coverage and access to health care services."

The IMS is on record as supporting universal health insurance coverage and access to health care services, but at this time supports no mechanism to the exclusion of others.

IMS will assist with PO, PHO development

The Iowa Medical Society Board of Trustees has decided the IMS will not spearhead creation of a statewide Independent Practice Association (IPA) but instead will assist Iowa physicians in pursuing managed care contracting opportunities and other cooperative ventures.

At its March meeting, the Board considered several recommendations from an ad hoc committee appointed to study the feasibility of creating an IPA. The Board decided the IMS will focus on helping physicians create Physician Organizations (POs) and Physician-Hospital Organizations (PHOs). This would include making available consulting services on a fee-for-service basis to enable physicians to evaluate options appropriate for their community.

(A PO is defined as a business entity formed of a group of physicians to pursue managed care contracting opportunities and other cooperative ventures, either independently or in cooperation with a hospital or other entity. A PHO is a business entity formed jointly with a group of physicians and a hospital or hospital system to pursue cooperative ventures. The January *Iowa Medicine* contained a feature story outlining these options in the new managed care environment.)

The Board directed IMS to identify all physician IPAs and POs in Iowa and schedule regular meetings for their representatives. IMS will also identify physicians with experience in IPA and PO development.

The 1994 House of Delegates will consider a recommendation from the ad hoc IPA committee that the IMS oppose 'any willing provider' legislation but support the right of physicians to apply to any managed care entity. The committee further recommended that managed care organizations be required to disclose criteria used to select, retain or exclude physicians, including the criteria used to determine geographic distribution and specialty of physicians.

Watch future issues of *Iowa Medicine* for developments on POs and PHOs. IM

A PO is a business entity formed of a group of physicians to pursue managed care contracting opportunities and other cooperative ventures.

Turn the page to find a chart comparing the AMA's Health Access America proposal and proposals from major specialty societies.

Health System Reform

continued

Reform proposals from AMA, AAFP, AAP and ASIM . . . .

1 AMA Plan *Health Access America*	2 American Academy of Family Physicians	3 American Academy of Pediatrics
ADMINISTRATION		
No new bureaucracy	National commission to establish and enforce global budgets and "component standards"	States administer insurance fund (payroll tax revenue) through private insurers
BENEFITS		
Similar to Clinton plan except stronger on preventive services. Mental health and substance abuse problems covered at same level as other medical conditions	Federally-defined basic benefits plan	Federally-mandated basic benefits plan
COST CONTAINMENT		
Negotiate goals and increase competition through consumer choice, fair tax incentives, insurance reform, administrative simplification and tort reform.	Private and public health plan initiatives, tort reform, administrative simplification, uniform payment system	RBRVS for pediatric, obstetrical services, administrative savings
CHOICE OF PHYSICIAN		
Patients can choose any physician or health plan, including fee-for-service, HMO, PPO or benefit payment schedule plan	Enrollees in basic plan required to have a "personal physician" (FP, GP, IM, Ped). Financial penalty for seeing specialist without referral by personal physician	Pediatricians are the most appropriate providers of care for children and adolescents
ELIGIBILITY		
Universal coverage of legal residents through reasonable, guaranteed coverage which may include employer-required insurance, individual-required insurance, individually-owned insurance and health IRAs	Universal coverage through employer-based plans and state-sponsored public plans for low income and employees of small businesses	Universal coverage through employer-required plans, replace Medicaid coverage for pregnant women and children
FINANCING		
Shared employer, individual and government participation, with broad-based taxes. No cuts in Medicare or Medicaid	Modified employer pay or play with state level public insurance pay option for small business	Employer play-or-pay mandate to extend coverage to children and pregnant women, income-related cost sharing

A side-by-side comparison

4 American Society of Internal Medicine

ADMINISTRATION

If a national board is established, a national physician review board should also be established

BENEFITS

A variety of plans (including managed care and fee-for-service) should each offer a standard benefits package

COST CONTAINMENT

Malpractice reform, more price information from providers and insurers, new physician payment system, insurance market reform

CHOICE OF PHYSICIAN

Guaranteed choice of physician

ELIGIBILITY

Universal coverage through employer-required insurance, Medicaid expansion, tax deductible health IRAs

FINANCING

Employer mandate with subsidies

ACS statement on single payer coverage

In testimony on February 10, 1994 before the House Committee on Education and Labor, Dr. David Murray, chairman of the American College of Surgeons (ACS) Board of Regents, outlined the College's views on the President's proposed health care reform plan. In particular, Dr. Murray expressed the need for any plan that might be enacted to ensure that Americans have an opportunity to obtain the high-quality health care services — including surgical services — they may need from any physician of their choice. Dr. Murray commended the President for his support of this objective and offered a number of suggestions for strengthening the choice features of the President's program.

However, the ACS chairman told the committee, "The Regents of the ACS are of the view that single-payer approaches to health care reform probably provide the best assurances patients would be able to seek care from any doctor of their choice. Single-payer approaches can probably be made more simple and more workable administratively."

Nevertheless, Dr. Murray made it clear that the College has not endorsed any of the specific health care reform plans being considered by Congress, but said the organization is prepared to work with any members of Congress, including the supporters of single-payer approaches, to address the critical freedom-of-choice issue.

Commenting on the ACS position, ACS Director Paul Ebert, MD, said, "Surgeons feel very strongly about the issue of patient access to high-quality surgical services and the Fellows of the College want to focus on that issue." Dr. Ebert said the Regents of the College believe the health care needs of the uninsured may obviously be addressed through comprehensive health reform strategies but that other more incremental steps could also be taken to focus on the particular health care needs of uninsured individuals and low-income individuals and families. He mentioned as an example of the latter the possibility of extending the existing Medicare program to uninsured individuals or perhaps even to those groups.

Dr. Ebert said the ACS intends to work closely with members of Congress and the Administration to achieve a workable plan for health care reform.

Legislative Affairs

Important bills survive funnel

Friday, March 4 was the first major deadline for the 1994 legislative session. To remain eligible for further consideration this session, most bills must have been approved by a committee in either the House or the Senate. The next deadline occurs on March 25 when bills must have passed one house and received committee approval in the other house. Appropriations, Ways and Means and leadership-sponsored bills are exempt from the deadline.

Following is a summary of IMS priority issues remaining after the March 4 deadline. Unless otherwise noted, the bills have been approved by a committee in either the House or the Senate.

Access to the state fiber optic network. The IMS is working to gain access for physician clinics and hospitals to the state fiber optic network for the purpose of telemedicine. This issue was not resolved as of press time.

CHMIS. **SF 2069**, the Community Health Management Information System bill, passed the Senate and the House in slightly different forms. The bill sets up an electronic system of claims processing and data collection using information from the claims form and requires use of a uniform claims format.

Helmet law. The helmet law has failed to receive committee approval in either house and appears all but dead for the year. Bills requiring safety training for motorcyclists and providing for allocation of diverted federal road funds are still eligible for consideration.

Tobacco. **SF 2298**, the IMS/Tobacco Free Coalition Bill, was approved by the Senate Human Resources Committee in a slightly modified form. The tobacco industry has been working to prevent this bill from being debated. SF 2298 extends the Clean Indoor Air Act to all restaurants but would allow restaurants with seating capacity of under 50 to designate their entire premises as a smoking area if they post signs.

The bill also eliminates the restriction on local non-smoking ordinances, requires greater separation between smoking and nonsmoking areas and designates the Iowa Department of Public Health as the enforcement agency.

Nurse practitioner prescribing. **SF 2053** will allow nurse practitioners to prescribe controlled substances and extends prescribing privileges to nurse anesthetists. Nurse practitioner prescribing rules would be done by the Board of Nursing in consultation with the Board of Medical Examiners and Pharmacy Examiners. An amendment which would have restricted prescribing by nurse anesthetists to rural areas failed. The IMS and Iowa Society of Anesthesiologists supported this amendment. The bill has passed the Senate and has been approved by a House committee.

Appropriations

Board of Medical Examiners. The House Appropriations Committee has recommended funding of $979,949 for the fiscal year beginning July 1. This compares to $966,939 approriated for the current fiscal year.

Medicaid. The Senate appropriations committee has approved a 10% increase in Medicaid reimbursement for obstetrical care and 5% for Early and Periodic Screening, Diagnosis and Testing (EPSDT) for children. No increase in

AT A GLANCE

The legislature is expected to adjourn in late April. Tuesday, April 19 is the 100th calendar day since the session began. Watch for a full report on the 1994 session in the June issue of Iowa Medicine.

A recent Des Moines Register *poll put gubernatorial primary candidates Terry Branstad and Fred Grandy in a dead heat. However, some political observers predict the voter turnout for the June primary will not be as high as the* Register *poll implies.*

Don't forget to attend the IMPAC reception which will kick off this year's House of Delegates. The reception will be held from 5:00 p.m.-10:00 p.m. Friday, April 15 at the Savery Hotel in Des Moines.

The IMS will sponsor a free seminar entitled Political Leadership in the 1990s *on Wednesday, June 8 at the University Park Holiday Inn in West Des Moines. To register, call Lyn Durante at the IMS.*

Contacting Your Legislators

Telephone numbers during the session:

Senators	**515/281-3371**
Representatives	**515/281-3221**
Governor	**515/281-5211**

Write to them at:
STATEHOUSE
Des Moines, Iowa 50309

You may also contact your legislator at home when the Legislature is not in session. If you don't know who your legislator is or need your legislator's home address and phone number, contact Lyn Durante of the IMS staff, 515/223-1401 or 800/747-3070.

reimbursement has been approved for other physician services.

State Medical Examiner. The Department of Public Safety recommended funding a full-time state medical examiner. This has not been included in the appropriation bill.

University of Iowa College of Medicine. The governor recommended $330,000 for the primary care initiative in the U of I College Medicine. He also recommended an additional $330,000 to be split between the U of I College of Medicine and the University of Osteopathic Medicine and Health Sciences. This amount has been reduced slightly in committee action.

Child abuse

HF 2261 expands the list of mandatory reporters, allows performance of physical examinations or tests which would provide medical support for a child abuse investigation, and reinstates the use of multidisciplinary teams.

SF 2009 requires the department of human services (DHS) to contact the physician within 24 hours of referring a child for a child abuse examination. The physician must report evidence of child abuse to DHS within 24 hours of the examination.

SF 2043 clarifies that physicians must report the presence of an illegal drug in a child which may have been caused by acts or omissions of anyone responsible for care of a child. Current law applies to reporting of acts or omissions of parents only.

SF 2292 requires bars and restaurants to post signs in restrooms warning that alcohol consumption during pregnancy may cause birth defects.

Mandatory physician assistant coverage. **SF 2211** would require health insurance companies to provide payment for services provided by a physician assistant within the PA's scope of practice if the same services are covered when provided by a physician. This bill has passed the Senate and has been approved by a House committee.

Free medical records copies to indigent patients. **SF 2020** would require physicians and hospitals to provide free copies of medical records to "indigent persons" (not defined) who are filing claims under the federal Social Security Act. The Act covers Medicare, Medicaid and social security disability claims.

The issue of limiting copying charges for medical records is being brought up regularly by state legislators and is under discussion for workers compensation. Physicians are requested to consult the "Principles of Cooperation Between Physicians and Attorneys" for guidance on developing appropriate charges for copies of medical records. This was mailed to IMS members in 1993. Call the IMS for a copy.

Contact lens prescriptions. **HF 2309** provides that only a person who possesses a written contact lens prescription for a patient may dispense contact lenses. After fitting and follow up care is completed, a patient may request a copy of the prescription from the optometrist or opthalmologist. Optometrists and ophthalmologists are also required to provide a copy of an eyeglass prescription to a patient. This bill is intended to clarify whether contact lenses can be provided without a prescription, such as through mail order houses.

Mental health

HF 2037 requires that applicants receive a summary of involuntary commitment proceedings.

HF 2134 requires the court to permit the patient advocate for the respondent's county of legal settlement to attend involuntary commitment proceedings.

HF 2236 limits a minor's right to object or consent to voluntary treatment for substance abuse or mental illness to minors age 14 or over. Current law sets no specific age of consent.

Marijuana for medical purposes. **HJR 2004** calls on the federal government to allow a "rational system of prescriptive access to marijuana" for medical purposes. IM

For more information or for the latest information on any legislative issue, call Becky Roorda of the IMS public affairs department. The telephone numbers are:

515/223-1401
or
800/747-3070

IMS position papers are available on legislative issues of concern to physicians.

Problem-filled Health System Reform Bill Passes Senate

The Iowa Senate has passed SF 2222, its own version of health system reform, but the bill's future is uncertain in the House. SF 2222 has serious problems. In its present form, the bill would likely cause cost-shifting, increase insurance premiums and result in more uninsured Iowans. The bill contains no liability reforms, the insurance provisions would not work, managed care plans would be required to provide direct access to a long list of practitioners (nearly everyone except specialist physicians) and the rules for accountable health plans are unncesessarily regulatory. As of press time, SF 2222 had been assigned to the subcommittee of Blodgett, Grundberg, Hammond, Haverland and Plasier and no action had been taken.

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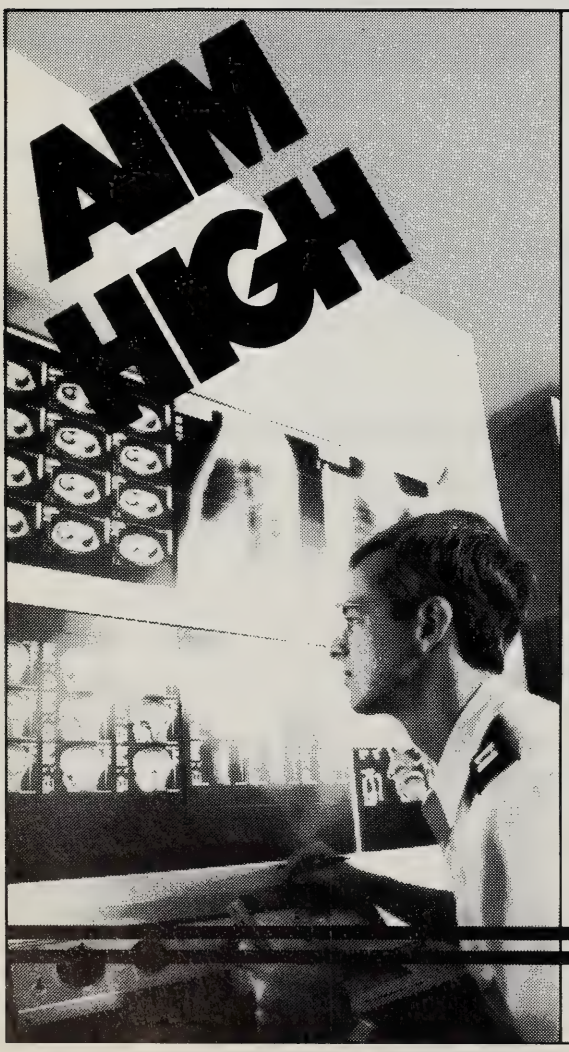
Owen Brodie, MD, joined CompHealth's locum tenens medical staff in 1989, after 21 years in private practice. Since then he's worked in temporary assignments in state facilities, filled in for attending physicians, covered for private practitioners across the country.

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AIR FORCE

Medical Economics

Medicare Single Payment Locality

The Health Care Financing Administration (HCFA) has received and is currently considering the application from Iowa to be a Medicare single payment locality state.

Staff at HCFA indicated the IMS would have been notified immediately if the request was going to be "rejected out of hand." In addition to letters of support the IMS included with its request, the Iowa Academy of Family Physicians also wrote to HCFA in support of a single Medicare payment locality for Iowa.

Upon acceptance by HCFA and then from the Office of Management and Budget, the proposal will be printed in the Federal Register (probably in June) with a 90-day comment period for letters of support or opposition to be sent to HCFA. If Iowa is granted single payment status, the effective date will be January of 1995.

Minnesota trying to collect tax

The IMS is receiving reports from member physicians that the state of Minnesota has contacted them about paying the health care tax on certain revenues of out-of-state physicians. As passed by the Minnesota Legislature, the tax is effective on services performed as of January 1, 1994.

The MinnesotaCare Act imposes a tax on the gross revenues received by physicians and hospitals for services provided to Minnesota patients.

For physicians outside Minnesota, the tax is 2% of the money they receive for treating Minnesota patients. Medicare and medical assistance payments are exempt.

The **IMS Update** section of the February *Iowa Medicine* contained an article outlining your options if the state of Minnesota says you are subject to the tax. For more information or for a copy of this *Iowa Medicine* article, call Tim Gibson or Linda Tideback at IMS headquarters, 515/223-1401 or 800/747-3070.

The IMS is participating in a lawsuit filed on behalf of eight physicians who are challenging the constitutionality of the tax as applied to out-of-state providers. As of press time, the Minnesota Supreme Court planned to hear the case sometime this spring.

More on the Data Bank

According to the Health Resources Services Administration, the National Practitioner Data Bank will now allow health care providers who have been reported to the Data Bank to "get their side of the story permanently on record without resorting to a formal dispute." In addition, the Data Bank will include more background information to those entities who query a provider's record, making it easier for the querier to interpret the circumstances that led to the report.

Previously, the Data Bank allowed providers to file a statement explaining their side of the dispute, but the statement would remain in the record only while the dispute was pending.

Medicare Carrier Advisory Committee

The Medicare Carrier Advisory Committee has been meeting since January 1992. The co-chairs of the committee are Kenton Moss, MD, Algona and John Olds, MD, Medicare Part B medical director. The committee includes a representative from every physician specialty society, a beneficiary representative and a hospital representative.

The purpose of the Medicare Carrier Advisory Committee (CAC) is to establish a formal, well-publicized method for physicians and the local carrier to address mutual issues of concern and for physicians to participate in the development of local medical review policy in an advisory capacity.

The Health Care Financing Administration has consolidated the local Carrier Advisory Committee (CAC) directories into one docu-

continued

AT A GLANCE

About 170 Des Moines physicians have formed what they call a "collaborative provider organization", an HMO owned and operated by the doctors themselves. According to an article in the Des Moines Register, *the organization represents "a revolt against recent efforts by the 'big two' hospitals in Des Moines to form similar organizations."*

Several IMS physicians are on the CHMIS Data Advisory Task Force, which is defining what data is needed, who will use the system and how data will be collected. IMS members on the Task Force are: Steve Vanourney, MD (chairman); Dale Andringa, MD; Louis Bannitt, MD; Kevin Cunningham, MD; Ron Grooters, MD; Jim Turner, MD; and Donna Bottorff of the IMS staff.

Medical Economics

continued

ment. Members are listed by region and carrier. The Iowa Medical Society has a copy of this directory. If you have a request concerning the committees in each of the nationwide regions, contact Donna Bottorff at the IMS, 515/223-1401 or 800/747-3070.

Medicare utilization reports expanded

The AMA plans to advise medical societies conducting fee review and help them reinstate fee review committees.

The Iowa Medicare Carrier is required by law to provide utilization information to individual providers through the Comparative Performance Reports (CPR) program. During 1992, carriers prepared CPR's limited to information about visits and consultations.

In 1994, CPR reports will be expanded to give physicians information on a wider range of services and procedures. Individual physicians are identified in the process of investigating broad patterns of care found to be significantly outside established norms. The following methodology was used to create this report:

- The carrier divides the number of times a physician reported a procedure code in question by the total number of Medicare patients treated.
- The number is then multiplied by 100 to yield the number of times that procedure was provided per 100 Medicare patients.

The same calculation is used for claims for all physicians in the physician's specialty and locality so that physician practices can be compared.

This program is informational. Physicians are not obligated to contact the Iowa carrier to discuss the CPRs they receive, but a staff member who is knowledgeable in the CPR process will be available to discuss inquiries related to the CPR process. There will be no follow-up action on the part of the Iowa carrier. All reports will be sent out by September 30, 1994.

Power to medical societies

The Federal Trade Commission has given medical societies the authority to require physicians accused of wrongdoing to participate in disciplinary proceedings, expel members from the society, disclose the unethical actions of disciplined physicians to the public and report them to hospitals and state licensing boards.

In addition, the FTC decision allows medical societies to advise patients and insurers regarding a physician's fee and help them decide whether to pay a disputed bill. Under prior law, medical societies were not permitted to bring "price-related proceedings" against physicians because the FTC believed such action would result in price fixing.

"Medical societies can now discipline members engaging in fee gouging when fraud and other abuses are present," commented Kirk Johnson, AMA general counsel.

The AMA plans to advise medical societies conducting fee review and help them reinstate fee review committees.

MediPASS goals reiterated

The Iowa Department of Human Services (DHS) developed a patient care system which provides a specified primary care physician for certain Medicaid recipients (families and children) residing is a seven-county demonstration area. This system is known as Medicaid Patient Access to Service System (MediPASS).

The goals of the system are to contain Medicaid costs, ensure appropriate utilization of services and enhance the quality and continuity of care through the direct "patient manager" physician-patient relationship. Physicians who were patient managers were also recruited to be members of a Peer Education Review Committee as mandated by law.

Committee members are: Frederick Aldrich, MD, a Des Moines pediatrician; Gary Anderson, DO, a Davenport family physician; Timothy Ranney, MD, a Council Bluffs family physician; Darwin Schossow, DO, a Des Moines family physician and James Stiles, MD, a family physician from Cedar Rapids.

The MediPASS program has produced considerable savings in projected Medicaid expenditures during its two years of existence. The DHS conducted an independent evaluation which compares Medicaid claims for fiscal year 1990 to fiscal year 1992.

The lower increase in costs resulted in an estimated savings of $11.7 million during fiscal year 1992 in Black Hawk, Jackson, Linn, Muscatine, Polk, Pottawattamie and Scott Counties.

The MediPASS program has been expanded to an additional 33 Iowa counties and this month will expand to Davis, Delaware, Fremont, Hardin, Jefferson, Madison, Tama, Van Buren and Wright. In April, the counties scheduled for MediPASS expansion are Benton, Cedar, Jones, Linn and Muscatine.

For more information about MediPASS, call 800/326-4132 or 515/226-8809.

Hepatitis B vaccine program revisions

Changes in packaging of Hepatitis B vaccine have made it available in 3 ml. vials rather than the previous 1 ml. vial. The following formula is to be followed when claims are billed to Medicaid for the vaccine:

•Each 3 ml. vial will be considered as 12 doses.

•Based on the age of the recipient for whom the Hepatitis B is billed, the computer will follow these guidelines — persons from birth to age 10 shall be considered as using .25 ml. (1 dose); persons age 11-19 shall be considered as using .5 ml. (2 doses); persons age 20 and over shall be considered as using 1 ml. (4 doses).

The new policy became effective January 1, 1994. Due to short notice on this change, physicians were not informed prior to the January shipment. Physicians received 3 ml. vials in January and a note with their shipment explaining the change. February shipments also include a report explaining the age break changes.

Call UNISYS, the fiscal agent for DHS, with any questions or comments about this policy change. The UNISYS number is 515/226-2200.

More physicians in group practice

Over a third (33.4%) of American physicians in direct patient care are in group practices, compared to 18% in 1969, according to a new AMA study.

The study, Physicians in Medical Groups: A Comparative Analysis 1993, finds that physicians in group practices — defined as three or more physicians — feel fewer restrictions on their autonomy. These physicians are also more apt to be board certified, more likely to contract with HMOs and tend to have somewhat higher incomes than physicians in solo practice.

The study also finds a third (34%) of American physicians in solo or two-physician practices and 32.6% in other patient care settings such as hospital employment.

Lead toxicity screenings

HCFA has released the following statement concerning lead toxicity screening related to the Early Period Screening Diagnosis and Treatment (EPSDT) program: "All children ages six months to 72 months are considered at risk and must be screened for lead poisoning. HCFA now requires the use of the blood lead test when screening children for lead poisoning . . ."

Beginning when a Medicaid-eligible child is six months old and at each visit thereafter, the provider must discuss with the child's parents or guardian childhood lead poisoning intervention and assess the child's risk for exposure. If a child has unacceptable blood levels, providers may require follow-up blood tests and initiate investigation into the source of lead.

This policy became effective January 5, 1994. For questions concerning risk assessment, screening or follow-up, contact the Iowa Department of Public Health, 800/972-2026 or (outside Iowa) 515/242-6340.

Oral cancer drug guidelines

Effective January 1, 1994, Medicare Part B is extended to include oral anti-cancer drugs approved by the FDA. Section 13553(a) of the Omnibus Budget Reconciliation Act of 1993 provides for coverage of oral, self-administered, anti-cancer chemotherapeutic regimen for a medically accepted indication. The oral form of the anti-cancer agent must contain the same active ingredient as the form of the drug which patients cannot self-administer.

Complete policy guidelines have been developed and are published in the February, 1994 *DMEC Diaglogue — Region D* newsletter.

HCFA has reviewed its documentation instructions in an effort to eliminate duplicative requirements. The review determined that most of the DMEC Certificates of Medical Necessity (CMN) include all the required elements of an order, including the detailed narrative description of the item. Therefore, for most items, the DMERC will consider the physician order requirement to be met when the physician signs the CMN.

However, HCFA now says the DMERC certificates for hospital beds, wheelchairs and lymphedema pumps are insufficient and is requiring an order for these items or use of alternatives published in the newsletter mentioned above. For more information on CMN guidelines, contact CIGNA at 800/899-7095. IM

Over a third of American physicians in direct patient care are in group practice.

Reducing Taxes with Tax Credits

Q. I keep reading about tax credit programs and how effective they are at reducing taxes. Can you tell me more about them?

A. One of the most effective and frequently overlooked ways of reducing federal tax liability is the Low Income Housing Tax Credit (LIHTC). Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

Investors typically receive tax credits equal to approximately 150% of their investment spread out over 10 years. So a $5,000 investment would yield tax savings of approximately $750 per year for the next 10 years, for a total of 7, 500. Depending on factors such as income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using LIHTC.

In addition to the credit there is potential for cash flow distributions in many programs. Generally all cash flow paid to investors is completely sheltered from taxes as well. Finally, when the properties in the portfolio are sold, they may be sold at a profit. Again a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The dollars raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. It is important to note that these are not crime infested, graffiti covered intercity housing projects. They are primarily new construction, garden-style suburban and rural apartment buildings.

The alternative to using LIHTC is simply to pay your taxes. For that you get no liquidity, no return and your holding period is forever. By using credits, you redirect dollars that would have been used to pay taxes back into your pocket to add to your net worth. This is why these programs are so widely used by corporations and individuals.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

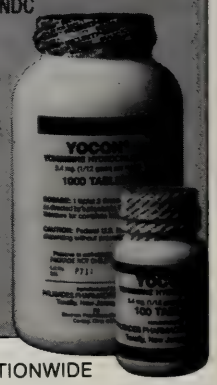
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Practice Management

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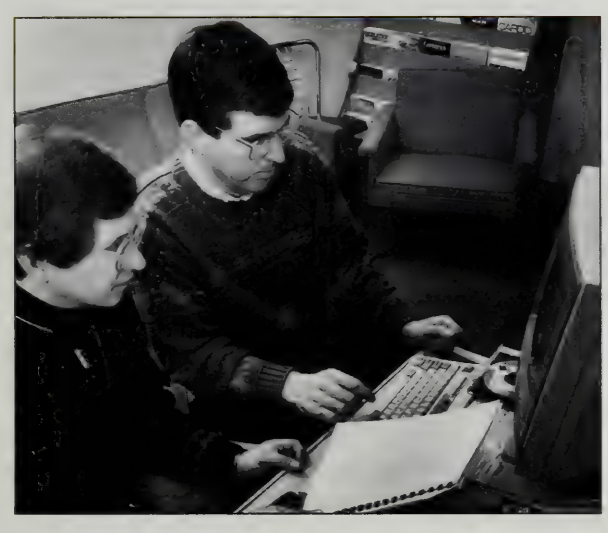
Iowa physicians now have immediate access to information about the care their patients receive at the University of Iowa Hospitals and Clinics (UIHC). A pilot program links them directly with the UIHC computer system, giving access to pertinent data such as lab, microbiology and radiology results from patient discharge summaries and other services.

Access to the UIHC system requires the physician to have a home or office computer, a special software package and a high-speed modum. Referring physicians sign the same confidentiality pledge as UIHC staff physicians.

Larry Severidt, MD, one of five family physicians with Manchester Family Medical Associates, says there are other uses for the system, "I can see using this system for UI continuing education and for interactive meetings we can attend without actually being there."

John MacIndoe, MD, associate professor of internal medicine, says the referring physician computer network could help physicians track their patients and gain insights into their care.

Other participants in the project are: Ried Boom, MD and John Tyrrell, MD of Manchester; Craig Thompson, DO of Strawberry Point; Paul Barber, MD of Maquoketa; Brian Meeker, DO of Vinton; and Matthew Sojka, MD of Washington.



Dr. Ried Boom (left) and Dr. Larry Severidt of Manchester use an on-line computer link to the U of I Hospitals and Clinics to get current information on their patients at University Hospitals.

Medical Business Specialist program

If you are employed in a medical office or clinic and want to further your professional development and get formal recognition for it, the Iowa Medical Society's new Medical Business Specialist program is for you.

The title Medical Business Specialist (MBS) identifies individuals who have successfully completed a designated curriculum of classwork and have been certified in the area of medical office business policies and procedures. The program is endorsed by the Iowa Medical Group Management Association (IMGMA).

The IMS worked with physicians, medical group managers, office personnel and

continued

Upcoming Workshops for You and Your Practice

April 12	Billing & Collections	Cedar Rapids
April 13	Billing & Collections	Mason City
April 20	Office Safety	Davenport
April 26	Office Team Skills	Ottumwa
April 28	Retirement...Plan Now	Dubuque
May 3	Retirement...Plan Now	Sioux City
May 10	Office Safety	Fort Dodge
May 11, 12	Upcoming HCFA Guidelines	Davenport
May 12	Can I Sell My Practice?	Davenport
May 19	Retirement...Plan Now	Waterloo

For more information about any workshop or seminar listed here, call Barb Cannon or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

AT A GLANCE

A personal touch in a physician's office creates a warm atmosphere, says a medical marketing specialist in a recent issue of Texas Medicine. *Patients enjoy seeing framed drawings done by the doctor's children or family photos. These things convey a pleasant message about the doctor as a person.*

To keep track of which educational handouts have been given to which patients, try using a self-inking stamp with all the pamphlets listed. When the patient receives a pamphlet, stamp the inside cover of the patient chart. Then, date and initial each stamp. This helps maintain an ongoing patient education program.

Practice Management

continued

other state medical societies to develop a certificate program that would offer high quality professional education at a fraction of the cost of technical school programs.

The IMS has identified 10 seminars which will help you develop the skills to become a Medical Business Specialist. Once you enroll, you can take the seminars as they fit your needs.

A special mailing describing the MBS program was sent to IMS members last month. If you didn't receive this mailing, call IMS headquarters, 515/223-1401 or 800/747-3070.

Have you thought about retirement?

This spring, the Iowa Medical Society is providing educational opportunities for member physicians and their spouses interested in retirement planning.

Programs will be offered April 28 in Dubuque; May 3 in Sioux City and May 19 in Waterloo. For more details, call the Iowa Medical Society at the numbers above. IM

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Focus on Risk Management

Managed care liability

Many physicians have joined managed care organizations or are contemplating doing so. Physicians are concerned about the impact of managed care on their liability exposure, but Lori Atkinson, MMIC risk management coordinator, says "physicians can take steps to minimize this exposure."

- Carefully review any "hold harmless" agreements. You may be assuming liability not covered by your insurance policy.
- Determine whether the plan limits referrals to doctors in or approved by the plan. Are there sufficient numbers and scopes of specialists?
- Determine how disputes about services will be handled. If a dispute arises over treatment you feel is required, note your disagreement in the patient's chart, document your concerns in a letter to the plan, call the reviewer and discuss the plan's limitations with the patient.
- Find out whether you can refuse to treat or terminate a physician-patient relationship with a managed care patient.

This is only a sampling of issues confronting physicians with the growth of managed care.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

Carefully review any "hold harmless" agreements. You may be assuming liability not covered by your insurance policy.

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Menopause and estrogen therapy

What is menopause?

During menopause, a woman's ovaries stop producing estrogen and a woman no longer has menstrual periods. (Estrogen is the hormone which controls the reproductive system in women.) The loss of estrogen after menopause causes changes in a woman's body.

When does menopause occur?

The average age at last menstrual period is 51. The changes brought on by menopause occur slowly, over time.

What are the early signs of menopause?

A year or two before menopause, you may notice changes in your menstrual cycle which may be caused by decreased estrogen levels. One of the earliest signs of approaching menopause is irregular periods. You may skip one or two periods or your flow may be lighter or heavier. Your period may last a shorter or longer time than is usual for you. Though periods tend to be irregular around the time of menopause, abnormal bleeding can be a sign of a problem in the uterus or its lining.

What bodily changes are caused by menopause?

Hot flashes are the most frequent sign of menopause. A hot flash is a sudden feeling of heat that spreads over part or all of the upper body. The skin may blush red or break out in a sweat. Flashes can come on at any time, but they don't last long. At night, they may disrupt sleep. Some women have hot flashes for a few months, some for a few years and some not at all.

Changes in the vagina may also occur as a result of estrogen loss. The vagina may be drier, causing pain during sex. Some women have vaginal burning and itching; others feel discomfort in the clitoris, part of the

Insert to *Iowa Medicine*, April 1994

female genitals involved in sexual stimulation. The urethra — the tube that carriers urine from the bladder — can become inflamed or irritated. (However, painful urination can also be a sign of urinary tract infection.)

Bone loss, a normal part of aging, is increased by menopause. This bone thinning is called osteoporosis. It increases the risk of broken bones — particularly the hip, wrist and spinal bones — in older women.

Heart and blood vessel disease (stroke) are more likely after menopause because estrogen appears to help prevent heart disease. Once ovaries stop producing estrogen, a woman's risk of heart disease and stroke increases over time to equal that of a man.

Menstrual changes

Although one of the earliest signs of approaching menopause is irregular periods, abnormal bleeding can sometimes be a sign of a problem in the uterus or its lining. It is important to be aware of bleeding that is not normal for you. Call your doctor if you:

- Have a change in your monthly cycle
- Have very heavy bleeding
- Have bleeding that lasts longer than normal
- Bleed more often than every 3 weeks
- Bleed after intercourse

Will I experience emotional changes?

Some women go through menopause without any emotional changes and even feel a sense of freedom from unwanted pregnancy and monthly periods. Others may be nervous, irritable, tired or mildly depressed. These symptoms may be linked to hormonal changes or to other factors such as lack of sleep or stress. It's important not to deny your feelings. Talk them over with your partner, a friend or your physician. Some women may wish to seek professional counseling.

Can I still become pregnant?

Even if you are experiencing signs of menopause, you may still be able to get pregnant. You are not completely free of this chance until a year after your last menstrual flow. Abstaining from sex during certain times in the menstrual cycle is a natural family planning method used by some women, but this method is not reliable during menopause because menstrual cycles are irregular.

Will menopause affect my sex life?

Menopause need not affect your ability to enjoy sex. The hormonal changes that cause vaginal dryness can be remedied with estrogen creams or lubricating jellies. Regular intercourse helps the vagina keep its natural elasticity and lubrication. If you have not been sexually active for a while, you may want to talk to your doctor about ways to make sex more comfortable.

Many women say sexual relations become more enjoyable at this stage of life.

Is there any relief for symptoms of menopause?

Most of the symptoms of menopause can be eased by taking estrogen, one form of hormone replacement therapy. Estrogen will not get rid of the symptoms entirely, but it can make them less frequent and intense. In particular, estrogen can relieve hot flashes and vaginal burning, itching and dryness.

Estrogen can also relieve some emotional problems stemming from loss of a natural hormone. However, estrogen will not solve problems that are part of the natural aging process.

Are there other benefits of hormone treatment?

Your doctor may recommend long-term hormone replacement therapy to relieve menopause symptoms, prevent osteoporosis and protect against heart disease. Hormone treatment works better to prevent osteoporosis if it is started at menopause but can be effective at any time.

Most women receive estrogen and another hormone called progestin. Progestin reduces some risks of taking estrogen. Progestin is similar to the progesterone your body makes before menopause. When progestin is used, you may have vaginal bleeding once a month.

How long does the treatment last?

The amount of each hormone needed to prevent low-estrogen symptoms varies among women. Treatment may last a number of years, even decades. If you take hormones to guard against osteoporosis and heart disease, long-term treatment is needed. Bone loss begins as soon as replacement hormone therapy is discontinued.

Women who choose not to take progestin should be monitored carefully for changes in the lining of the uterus.

How do I receive hormone treatments?

Hormone treatment is most often prescribed in pill form. Sometimes, estrogen is given through a patch on the skin. Estrogen creams are made for use in the vagina.

New ways to give hormones are being studied, including vaginal suppositories, injections and implants.

Regular screening tests

The following lab tests should be performed on a regular basis.

TEST	FREQUENCY
Pap test	Yearly; after 3 normal annual exams, it may be done less often
Mammogram	Baseline at age 35-40; every 1-2 years between ages 40 and 50; yearly after age 50
Cholesterol	If normal, every 5 years
Screening for colon cancer	Every 3-5 years after two normal annual exams in a row
Thyroid function	Every 5 years

Are there risks to hormone replacement therapy?

Like any medication, hormone replacement therapy is not risk free. The decision to begin treatment depends on a woman's medical history, a family history which may put her at risk for cardiovascular disease or cancer, her symptoms and her risk of bone loss. Some women are less likely to develop problems due to low estrogen and therefore choose not to use hormones.

Side effects of hormones

If you experience any of the following side effects after beginning hormone replacement therapy, call your physician:

- ♦Vaginal bleeding (if you are also taking progestin)
- ♦Breast tenderness
- ♦Fluid retention
- ♦Swelling
- ♦Mood changes (depression, irritability)
- ♦Pelvic cramping

One concern about estrogen use is that it may cause cancer of the uterus lining (the endometrium.) Obviously, women with no uterus don't have to worry about this. For women with a uterus, it is believed that taking progestin along with the estrogen reduces this risk. In fact, women taking both estrogen and progestin have a lower risk of endometrial cancer than women who take no hormones at all.

Will hormone therapy affect my risk of breast cancer?

Most studies suggest no link between hormone replacement therapy and breast cancer. However, some studies indicate a woman's chances of developing breast cancer increase a small amount if she has been on hormones for more than 15 years. Link other women their age, women taking replacement hormones should have regular breast exams and mammograms.

Who should decide whether this treatment is right for me?

Feel free to discuss all these issues with your physician. Whether or not to begin hormone treatment is a decision you and your doctor should make after fully weighing the risks and benefits. Although most women benefit from taking estrogen, if you have had breast cancer, endometrial cancer or liver disease, estrogen is usually not recommended unless your menopause symptoms are so severe that you feel the benefit is greater than the risk.

How can I be at my best after menopause?

The life expectancy of women has increased and you will have many good years after menopause. Never underestimate the benefits of eating a balanced diet with sufficient calcium (1,500 mg/day), exercising regularly and getting routine physical check-ups. Adjusting to the changes of menopause will refocus your attention where it belongs — on a healthy life.

This information on menopause has been compiled from publications of the American College of Obstetricians and Gynecologists. As a service to IMS member physicians, this insert may be photocopied for placement in clinic reception areas. Original inserts may be purchased from the IMS for 15 cents each. Call Jane Nieland or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

Newsmakers

Trisomy 22 in an Iowa newborn

Dear Editor:

After reviewing my article "Trisomy 22 in an Iowa newborn" in the January 1994 issue of *Iowa Medicine,* I realized that there were no acknowledgments for the contributions of Steven Suvalsky, MHS, pathologist's assistant from the Department of Pathology of Iowa Methodist Medical Center. Thanks to his pathological findings, we were able to learn more about the patient referred to in the article. I must have inadvertently left his name off the acknowledgements when I submitted the article.—*Sergio Golombek, MD, Kansas City.*

Letter to the Editor

Deceased members

Virginia Thompson, MD, 84, life member, anesthesiology, Rippey, died February 18

Awards, appointments, etc.

Dr. John Grant, Ames orthopedic surgeon, has retired after 32 years of practice at McFarland Clinic. **Dr. John Fieselmann,** assistant professor and director of affiliated programs for the Department of Internal Medicine at the UI College of Medicine, has been named director of the Office for Clinical Outreach Services and Contracting for Patient Care. The office is sponsored by UI Hospitals and Clinics/Faculty Practice Plan. **Dr. Val Sheffield** and **Dr. Edwin Stone,** UI College of Medicine, are directors of the newly-created Carver Laboratory for Ophthalmic Molecular Diagnosis. The laboratory, funded through a three-year, $450,000 award from the Roy J. Carver Charitable Trust of Muscatine, will allow for greater collaboration with scientists around the world who treat families affected by eye diseases. **Dr. Stanton Danielson,** Altoona Family Care Center, was named the 1993 Iowa Family Practice Educator of the year at the Iowa Academy of Family Physicians' 45th Annual Meeting and Scientific Assembly in Des Moines. **Dr. Barbara Evans,** Des Moines, has been board certified by the American Board of Ophthalmology. **Dr. George Winokur,** UI College of Medicine, Department of Psychiatry, has received the Lifetime Achievement Award from the International Society of Psychiatric Genetics. **Dr. Stephen Wolf** of Pediatric Surgical Associates, Des Moines, recently made an oral presentation entitled "Laparascopic Incidence of Contralateral Patent Processus Vaginalis in Boys with Clinical Unilateral Inguinal Hernias" at the American Academy of Pediatrics annual meeting in Washington, D.C. This work will be published in the *Journal of Pediatric Surgery.* Des Moines rheumatologist, **Dr. Nathan Josephson,** has been appointed coordinator of the newly-established Des Moines Area Medical Education Consortium. Cedar Rapids internist, **Dr. William Galbraith,** has joined the UI Department of Internal Medicine staff. Dr. Galbraith was in private practice for nearly 29 years. **Dr. Michael Welsh,** professor of internal medicine, UI College of Medicine, is the recipient of the Paul Di Sant'Agnese Distinguished Scientific Achievement Award from the Cystic Fibrosis Foundation for his seminal work on the basic cell defect in cystic fibrosis and his efforts to use gene therapy to correct this defect. **Dr. Matthew Anderson,** a resident in pathology at UI Hospitals and Clinics, received the 1993 International Distinguished Dissertation Award of the Council of Graduate Schools at a ceremony in Washington, D.C. **Dr. Kendall Reed,** general surgeon, has been named the president of the Des Moines Mercy Hospital Medical Center staff. **Dr. Robert Smits,** an otolaryngologist, is the president-elect and **Dr. Patricia Overton-Keary,** an internal medicine specialist, is secretary-treasurer. **Dr. Dean**

continued

AT A GLANCE

Brenton Koch, a third year medical student at UI College of Medicine, is a winner of the 1994 AMA/Glaxo Achievement Award. The awards are given to 25 medical students and 25 resident/fellows who have demonstrated strong non-clinical leadership skills.

Dr. Virend Somer received, the Cournand and Comroe Young Investigator Award at the national meeting of the American Heart Association in Atlanta, Georgia. Dr. Somers is assistant professor in the Division of Cardiovascular Diseases, Department of Internal Medicine, UI College of Medicine.

Newsmakers

continued

Gesme, Cedar Rapids immunologist/oncologist, has been elected to the Board of Directors of the National Coalition for Cancer Survivorship, based in Silver Spring, Maryland. **Dr. John Paschen**, pediatrician at McFarland Clinic in Ames, recently took a one month leave of absence to volunteer in the impoverished town of Clarksdale, Mississippi which has only minimal laboratory and no x-ray capabilities. **Dr. Patricia Winokur**, assistant professor in the Department of Internal Medicine, UI College of Medicine, has been named the 1994 Burroughs Wellcome Fund Young Investigator in Virology. The award is administered by the Infectious Diseases Society of America. **Dr. Bradley Doebbeling** and **Dr. Larry Schlesinger**, Department of Internal Medicine, UI College of Medicine have received 1993 Young Investigator Awards from the Interscience Conference on Antimicrobial Agents and Chemotherapy.

IMS Annual Scientific Session and House of Delegates will be held at the Savery Hotel in Des Moines April 15-17.

New members (as of January 1994)

Clinton

Ahmed Elahmady, MD, internal medicine/gastroenterology

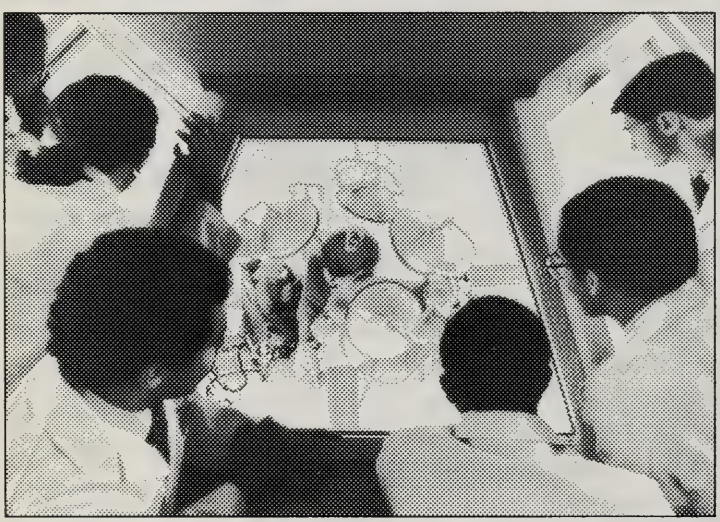
Des Moines

Maria Flickinger, MD, obstetrics/gynecology
Robert Hoyt, MD, cardiology
Kathy Santangelo, MD, cardiothoracic surgery

Iowa City

James Christensen, MD, gastroenterology
Randy Delcore, MD, resident
Gerry Funk, MD, otolaryngology/head & neck
Michael Kienzle, MD, internal medicine/cardiology
James Krieg, MD, resident
Joel Sorosky, MD, obstetrics/gynecology
Daniel Vandersteen, MD, resident

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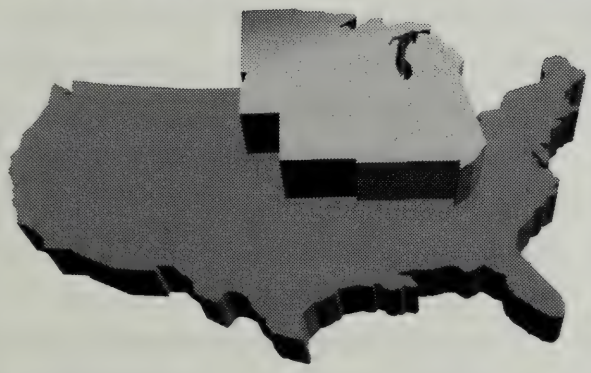
Student Ambassador Program

Students in eastern Iowa now have the opportunity to touch a human heart or leg bone and learn what the inside of a hand looks like, thanks to the Medical Student Ambassador Program at the UI College of Medicine. Last year 19 volunteer ambassadors presented 15 programs in Iowa City schools. Models, preserved tissue, slides and other resources are used during the presentation, which is tailored for K-12th grade students. IM



First year medical student, Dan Fitzpatrick, with students at Lemme Elementary School, Iowa City.

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MEDICAL EDUCATION and health system reform

There is increasing pressure on medical schools to produce more primary care physicians and fewer specialists. Health system reform proposals which rely on a "gatekeeper" approach will keep public attention on this issue. Educators at the University of Iowa say physician training must meet all of society's needs.

The education of physicians is an intrinsic component of comprehensive health care reform. America has an undersupply of primary care physicians, especially in inner-city and rural areas. Of over 15,000 medical students awarded the MD degree annually during recent years, fewer than one in four will enter a primary medical practice.

Changes in health care financing and reorganization of medical practice present a necessity for curricular renewal in medical education.

For the past two years at the University of Iowa College of Medicine, the faculty committee charged with responsibility for the curriculum have organized a thorough review of the full four-year course of study for medical students. The study has been completed and the committee is now developing options for curricular revision.

A major issue that must be addressed in the new curriculum will be the college's plan to meet a requirement that ***"all schools must offer a core curriculum in primary care, utilizing the disciplinary or multi-disciplinary approaches involved in the delivery of such care."*** This is the central requirement of the Liaison Committee on Medical Education, the national accreditation committee for medical schools.



RICHARD NELSON, MD
Dr. Nelson is associate dean of the University of Iowa College of Medicine and a regular columnist in Iowa Medicine.

Good record for 1993 class

The UI College of Medicine has had the elements of primary care in the curriculum for some time, formally introduced in the Introduction to Clinical Medicine course in the second year and continuing through the many clerkships of the final two years.

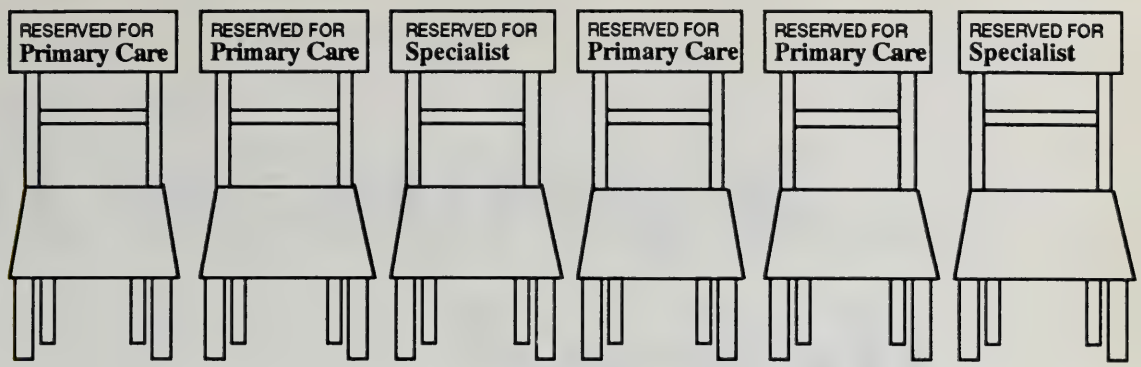
We believe we have had considerable success in producing primary care physicians. Among medical schools graduating more than 100 students annually, the University of Iowa leads the nation in the percentage of its students (21.9%) entering family practice for the years 1986-93.

The 1993 class included 93 students (61% of the class) entering one of four primary care disciplines: family practice, internal medicine, obstetrics/gynecology and pediatrics.

We have had considerable success producing primary care physicians.

Due to subspecialization, the actual percentage of a typical U of I class likely to enter primary care practice after three years of residency is about 40%. If a greater number of primary care physicians are needed in Iowa and throughout

MEDICAL SCHOOL



the nation, the UI College of Medicine and other medical schools must align their educational objectives with community needs.

Graduate medical education programs will also need to increase the number of physicians completing residencies in primary care.

Calls for a rational plan

Health system reform can support these objectives by acknowledging and adhering to these five basic philosophies:

1. There must be a rational plan for funding medical education. Society, especially its policymakers, must acknowledge that medical education at all levels is currently subsidized by the clinical care of patients.

Therefore, if the direct financing of patient care is not to include a component for education in those centers with programs, a funding stream must be established for this purpose.

That funding stream ideally should derive from the care of all citizens, not only those financed through government-supported programs as is currently the general case.

2. The resources to support medical education must follow the student or resident into a variety of learning settings, including community primary health care practices and hospitals.

This flexible financing will permit medical schools and graduate medical education programs to broaden their curricula and training through the support of teaching faculty in more diverse community-based arrangements.

3. Despite the need for larger numbers of primary care physicians, society must recognize that we must continue the training of specialists and subspecialists to provide the next generation of advanced health care. The issue is not whether to train such individuals, but to support the numbers required to provide necessary care.

4. We must recognize the roles and responsibilities of health care professionals other than physicians, including physician assistants and advanced practice nurses, in our heterogeneous health care system.

Academic health sciences centers must model in their education programs the interdisciplinary health care practice expected in the community.

5. Society must continue its support of basic and applied research. The fundamental understanding of disease mechanisms has progressed to permit us to realistically project the prevention or cure of major systemic diseases.

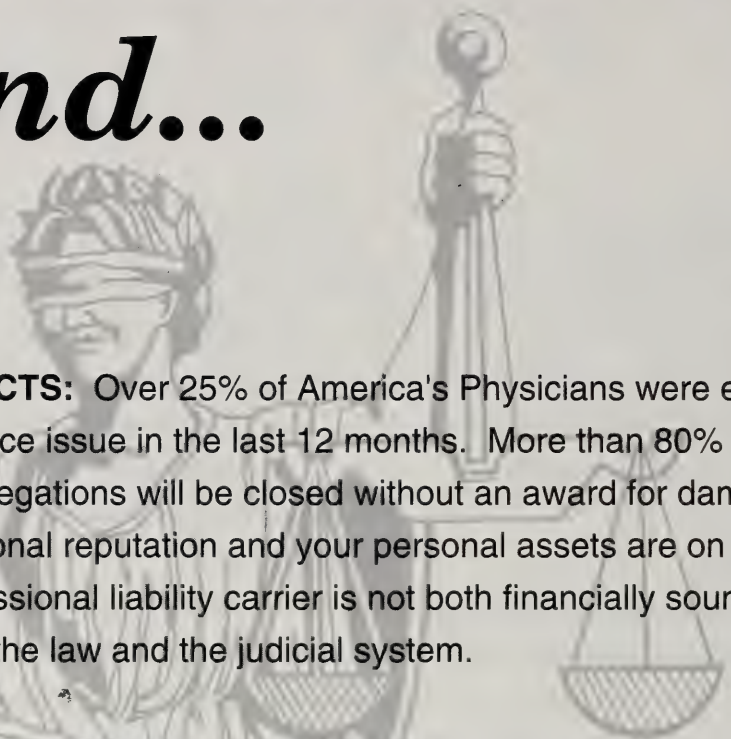
Poised to meet future needs

The large majority of students who began their medical education in the fall of 1993 will finish their training in the year 2000. The future of these medical professionals will be what we aspire for them.

At the UI College of Medicine, we will endeavor to educate the number and kind of physicians necessary to meet Iowa's needs at the beginning of a new century. IM

We must continue training specialists and subspecialists to provide the next generation of advanced health care.

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What about the needs of your patients?

Barely a day passes without the media focusing on some aspect of what has been labeled "health care reform" or the "health care crisis".

While the major focus has been on the delivery and financing of health care, the intense media interest is reflected by industrious coverage of a broad range of complex topics.

While there are significant differences in opinion about the problems and solutions, there is general agreement that the fundamental changes already underway will continue to occur at every level of the nation's health care system. Some changes such as the impingement on a patient's freedom to choose a physician or on a physician's freedom to choose their consultant are already creating difficulties. These changes are being driven by the escalation of health care costs and by impaired access to health care experienced by segments of our nation's population. These are serious problems for everyone and they must be solved. Some changes currently proposed could have disastrous consequences that would erode the quality and availability of health care for Iowans well into the next century.

In spite of this, I find many reasons to feel confident that a bleak outcome is not inevitable.

It is hard to overestimate the severity of the health care problems that face us. In spite of this, I find many reasons to feel confident that a bleak outcome is not inevitable. As the UI College of Medicine begins to tackle the difficult problems facing academic medicine in 1994 and beyond, a quote from Albert Einstein provides insight: "In the middle of difficulty lies opportunity."

If academic medicine is to help forge solutions to problems facing our health care delivery system, the basic culture of academic medicine will have to change. The cultural change required is of such a magnitude that it will shake academic medicine the way Einstein's perspective of matter shook physics. Achieving such a fundamental cultural change in academic medicine will require strong, visionary leaders who create an environment that promotes and equally rewards excellence in patient care, education and scholarship. The cultural transformation will need to assure that each of the three legs of the academic stool is strengthened by mechanisms that consider societal and community needs during assignment of priorities. Our cultural change needs to generate an academic health center that is functionally seamless so traditional departmental lines are no longer barriers to teamwork. Our cultural change needs to promote stronger partnerships between the College of Medicine and community physicians and hospitals.

During the past year the College of Medicine has made significant progress in addressing some of the challenges presented by health system reform. The College and University of Iowa Hospitals and Clinics sponsored a highly

continued



RICHARD LYNCH, MD

Dr. Lynch is a pathologist and is interim dean of the University of Iowa College of Medicine.

Dean's message

continued

successful lecture series on the impact of health system reform on academic health centers. College of Medicine deans meet regularly with the Family Practice Advisory Committees around Iowa. The establishment of the Des Moines Area Education Consortium is an important achievement that will further develop educational programs for residents and medical students at sites in the Des Moines area.

We have established clinics in Lone Tree and Sigourney and specialty clinics in numerous communities throughout eastern Iowa.

In an effort to integrate and coordinate our clinical outreach programs and to better serve community physicians, the College and the UIHC have developed a Joint Office for Clinical Outreach Services and Contracting for Patient Care. A brochure describing this new office will be distributed to IMS members.

In response to community invitations, we have established clinics in Lone Tree and Sigourney and have scheduled specialty clinics in numerous communities throughout eastern Iowa. To increase our primary care capacity, new faculty have been recruited in the Department of Family Practice and in general medicine and pediatrics. The College has submitted a plan to revise the promotion and tenure policy and to develop a non-tenure faculty track for clinician-educators.

The College of Medicine continues to be a national leader in graduating medical students who select primary care residencies. In 1993, 31% (47) of our seniors selected family practice residencies and 30% (46) selected residencies in general internal medicine, general pediatrics or obstetrics and gynecology. The College was second in the nation in the number of graduates who entered residency training in family practice.

As a College of Medicine, we have multiple missions. Health system reform will have an impact on each one of these missions, just as it will have an impact on the missions of community physicians and hospitals. As our nation formulates the details of health system reform, each of us must be vigilant to assure the most important element in the health care system — the patient — is not forgotten.

That such a possibility could occur was brought home to me recently while listening to a briefing on health system reform presented to a visiting dignitary from overseas. When the presentation was finished, the visitor said: "It sounds like your country has given a lot of thought to the needs of hospitals, physicians and other providers, large employers, third party payers, administrators and academic health centers. What about your patients?" IM

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The Journal
of the Iowa Medical Society

UI gene research holds promise for everyday practice

● *EDITORS NOTE: This article was provided by the University of Iowa Health Science Relations Department. It was based on interviews with physicians involved in genetic research at the UI.*

News headlines herald a new genetic discovery almost every week. While genetics and the emerging field of gene therapy may seem removed from your everyday practice, they really aren't. Genetic research builds on what doctors have always known — family history is very important in treating patients.

"The results of today's genetic research certainly will affect how a physician deals with patients," says Dr. Val Sheffield, assistant professor of pediatrics in the Division of Medical Genetics. In the past two years, Sheffield and his UI ophthalmology colleague, Dr. Edwin Stone, assistant professor of ophthalmology, have mapped seven different genes for a variety of inherited eye diseases.

"It's not that every practicing physician will be able to offer a patient a sophisticated genetic therapy for a rare disease. A host of very common diseases such as diabetes, high blood pressure and a variety of cancers have a strong genetic component. Genetic research can make screening and diagnosis of these problems easier," Sheffield says.

Identifying high risk

Being able to identify those at highest risk for a disease will allow physicians to concentrate health care resources on those who need them most, as well as provide early intervention. "With hereditary glaucoma, for example, the children in the family are at 50% risk of having glaucoma. Before the gene was mapped, you had to follow all the children to see who would develop the disease," he explains.

Examining the cause of a disease at the most basic, molecular level will also lead to better traditional therapies. "The only way to discover new therapies and develop better preventive measures is through medical research. You have to understand the mechanisms of a disease, including the genetic component, in order to find the best treatments," says Dr. Michael Welsh, professor of internal medicine and Howard Hughes Medical Institute investigator.

"The general public is also becoming more aware of genetic research. For example, many people already show up at the doctor's office with a copy of the latest news story about a gene being found for colon cancer, asking if they're at risk because a sister or brother or cousin died of the disease," Welsh says. "We are now only riding the front wave of this. The general public will want to know how they can use genetic information to improve their health."

As the technology gets better, the costs of screening will drop. One day, everyone — not just those believed to be at higher risk — may be screened for a host of problems. "All newborns in Iowa are now screened for phenylketonuria. It's conceivable that one day a battery of genetic screening tests may be standard procedure," Sheffield says.

Much public attention

Although genetic research may be improving traditional therapies, the more experimental direct gene therapy has gotten the most public attention over the past year, often being hailed as the big hope for certain diseases. But the field is new and uncertain. "Gene therapy will be very expensive, and how effectively we will able to deliver it

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for April 1994.



UI gene research holds promise for everyday practice

continued

across the population remains to be seen," Sheffield says.

Welsh, whose first experimental trials of gene therapy for cystic fibrosis made national headlines in 1992, agrees "gene therapy holds great promise, but we don't know if it will be realized and for which diseases.

"Today we're testing gene therapy in classic genetic diseases, such as cystic fibrosis and certain types of cancer, which are lethal. If this work goes well, we may be able to come up with genetic therapies for diseases that are debilitating, but not necessarily lethal.

"For example with arthritis, we may be able to develop a gene therapy that inhibits inflammation in the joint; for diabetes, you may be able to achieve gene transfer to the pancreas; and with angioplasty, it may be possible to stop restenosis by inhibiting the inflammatory process that contributes to it," Welsh says.

For some diseases such as cystic fibrosis, the best chance for any therapy appears to be gene therapy. Another such case is brain tumors.

"Glioblastoma multiforme patients have a 12- to 14-month survival, using all the treatments currently available," says Dr. John VanGilder, professor of surgery. "These brain tumors tend to infiltrate the brain, so it's difficult to remove them entirely." VanGilder and Dr. Ken Culver, executive director of the Human Gene Therapy Research Institute at Iowa Methodist Medical Center in Des Moines, are awaiting approval from the U.S. Food and Drug Administration to test gene therapy in 15 patients.

Brain is ideal model

The brain is an ideal model for gene therapy because the cells don't regenerate. Once the genetically altered substance is inserted into the brain, it is only absorbed by the rapidly dividing tumor cells. "This allows us to kill the tumor cells without altering normal brain cells," he says.

"At this point, gene therapy may be the best hope for dealing with brain tumors. We haven't advanced much over the past 20 years with respect to treatments for brain tumors," VanGilder explains. "Gene therapy may be the way to go, but we need to conduct the clinical trials."

Meanwhile, the UI is assembling a core of clinicians and basic researchers in a variety of disciplines to further develop research and focus on genetic therapy research. Already, the UI has the Cooperative Human Linkage Center, an NIH-funded center that is part of the international Human Genome Project, which aims to map the entire human genetic code.

The field of genetics goes beyond the research portion of an academic health center's purpose. It is intimately related to all three missions of an academic health center, Welsh explains. "Genetic discoveries are key to better diagnosis and treatment for all patients. It is also important to educate medical students and practicing physicians, through continuing medical education, about how to use genetic information and how to counsel patients. Finally, devoting resources to research is the only way to develop improved treatments and better understand disease."

VanGilder adds, "This is a rapidly developing field and we don't know where it will lead. It holds terribly exciting prospects for those with a lethal disease such as this type of brain tumor."

"Is the potential of gene therapy science fiction? I don't think so," Welsh says. "Advancing gene therapy is going to take lots of work. It *will* fail in some cases, but it should be successful in other areas. You take a leap forward and then take a few steps backward before you go forward again."

Leprosy in Iowa: 1860-1954

● *Richard Caplan, MD*

In a special 2-part series, the author describes the importation of Hansen's Disease into Iowa. Part 1 discusses leprosy in early Norwegian immigrants.

As people are mobile over the earth, so too are diseases. Sometimes diseases flourish in the new locale; sometimes they perish because the environment proves too hostile. This story concerns the disease leprosy, or better—because I accept contemporary efforts to remove the ancient stigma attached to it—Hansen's Disease (HD), named for Dr. Armauer Hansen of Bergen, Norway, who first discovered the causative bacillus in 1873.

I make no claim that HD had never appeared before 1860 in the area now called Iowa, but it seems likely it never had. As recently as at least 1984 there had been no report of the disease in a full-blooded Native American within the United States, though this can't be said of Native Americans in Mexico and the rest of Latin America.[2] Europeans probably first transmitted the infection to this hemisphere (for example, Spanish explorers, slave traders or French settlers in the Maritime provinces of Canada, some of whom, as Acadians, migrated onward in about 1760 to become the "cajuns" of Louisiana). HD has been known in the U.S. since a 1758 case in Florida.[3] Especially important to the Iowa story is the Norwegian migration to the U.S. which—if we omit the peregrinations of the Vikings—is first marked by the voyage of the ship "Restaurationen" from Stavenger near Bergen in 1825.[4] In the subsequent 40 years, 77,874 Norwegians arrived in the United States.[5]

Throughout the Middle Ages, when there were perhaps as many as 20,000 European leprosaria during the 1400s, HD certainly thrived in Scandinavia, even north of the Arctic Circle in Lapland. Though most of the 12 to 15 million persons thought to be infected today live in warm climates, the current presence of the disease high in the mountains of chilly Nepal can help persuade us that the geography and climate are not as directly important as the socio-economic factor of poverty with its attendant malnutrition, crowding and general diminishment of health.

Early immigrants probably infected

The western part of Norway, centered around the seaport city of Bergen, was a major locus of HD into the early part of this century. In 1852, 1.1% of that nation's people were thought to be infected, with 7% of those persons living in the western districts.[6] Dr. Hansen grew up in Bergen and thus had his interest drawn to that problem of great prevalence and distress in his native region. The early emigrés to the U.S. after 1825 surely included some persons actively infected, plus others who were incubating this disease that evolves slowly, so their illness became manifest even years after their arrival. The newcomers fanned out to various parts of this country, the upper midwest proving to be a popular destination.

Wisconsin, northern Illinois, Iowa, the Dakotas and especially Minnesota received their share of Norwegians. At the 1894 Congress of American Physicians and Surgeons, Dr. James Hyde, telling of some 560 cases of HD previously recognized in the United States, offered the approximation that Iowa housed 20 cases.[7] The majority of Norwegian settlers in Iowa came to the area of Decorah in the northeastern county of Winneshiek,

Richard Caplan, MD
Dr. Caplan is a professor of dermatology and coordinator of the program in medical humanities, University of Iowa College of Medicine.

Leprosy in Iowa: 1860-1954

continued

not far from the Minnesota border, where now an excellent museum displays the Norwegian-American experience. The Decorah *Public Opinion* of October 18, 1988, in a historical article dealing with the process of locating old gravestones, said "Records also indicate that 1882 was the year that three cases of leprosy were reported in Winneshiek County."[8] I cannot verify these cases.

A side-story of special interest concerns a visit Dr. Hansen made to Minnesota in 1888 to examine families in which the disease had appeared.[5] He was particularly eager to examine the children, in whom not a single instance of the illness had been found. This was an enormously important part of his effort to discredit the theory, especially promulgated by two famous Norwegian leprologists, Daniellsen and Boeck, that leprosy was a disease of heredity. To put that theory securely to rest would of course buttress Hansen's firm belief that the disease was contagious, not inherited, and that the cause was the bacillus known as *Mycobacterium leprae*, which he had been the first to describe in lesions taken from patients in the Bergen leprosy hospital, where he was the director.

First national registry

The rapid disappearance of HD from the Norwegian immigrant population in the U.S. is attributed by most authors to the substantial improvement in their standard of living. Similar explanations have been offered for the corresponding greatly decreased prevalence of tuberculosis in the U.S. during the pre-antibiotic first half of this century. The same decreased prevalence of HD occurred in Norway during those years.

The first national disease registry ever attempted, the Norwegian national leprosy registry, begun in 1856, was still active at least until 1971, at which time it had tallied 8,218 persons, four of them still alive. "The highest number of patients alive at any one time was 2,858 in the year 1856."[6] It is possible Norway has had sporadic cases imported from distant sites, whether recognized or not, just as has happened in Iowa.

The principal resource for the 19th century part of my Iowa story is a book published in 1886 by the Kingdom of Hawaii.[9] The Hawaiian Minister of Health, bedevilled by a rapidly advancing epidemic of HD among the native Hawaiian people, sought from Hawaiian consuls in other nations information which he hoped would prove helpful to policy deliberations at home. Included in that compendium is a response from the Hawaiian consul in the U.S. that includes a section concerning the disease in Iowa. It states the names of seven Norwegians known to have died of the disease in Winneshiek County, Iowa between 1863 and 1877 plus one more who died in central Iowa in 1883. Because Iowa began collecting vital statistics only in 1880, I could find no other record of the seven deaths in Winneshiek County. The eighth death, because it happened in 1883, permitted me to study the original death certificate of Ole K. Hill, who lived in a Norwegian enclave in central Iowa (Cambridge and then Nevada). That certificate states he was born in Norway and died at age 39 of "elephantiasis graecorum," an old name for leprosy, from which he had suffered for 10 years. I was able to learn that Mr. Hill, a successful candidate of the Republican party, served as Recorder of Story County from 1875-1881. He did not stand for re-election in the fall of 1880, probably by then in difficulty with his HD. The census of 1880 for Nevada enumerates Ole Hill and his wife, R.K., but no children.

Death certificates in Iowa were not cross-indexed by disease and I have not read through the entire log looking for other instances. My further efforts to locate any direct information about these eight Norwegian patients or any others from the 19th century in Iowa have been unavailing.

References

References noted in this article are available from the author or the editors of *Iowa Medicine*.

In Part II, Dr. Caplan discusses modern day cases of HD in Iowa.

IMS
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The Throckmorton Surgical Society and
Iowa Chapter, American College of Surgeons
SPRING MEETING

Surgical Symposium on Critical Care
Friday, May 6, 1994

Impact of Regionalization of Health Care on Surgery
Saturday, May 7, 1994

GUEST FACULTY

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King/Drew Medical Center
Los Angeles, California

T. James Gallagher, M.D.
Professor of Anesthesiology and Surgery
Chief, Division of Critical Care Medicine
Medical Director, Hyperbaric Medicine
Shauds Hospital
University of Florida College of Medicine
Gainsville, Florida

Loren D. Nelson, M.D.
Associate Professor of Surgery
Vanderbilt University Medical Center
Nashville, Tennessee

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Des Moines, Iowa

TOPICS

May 6, 1994

ICU monitoring • Early enteral feeding in the critical care patient • Mechanical ventilation • Prevention of nosocomial infections • Multiple systems organ failure • Future developments in surgical critical care • Use of neuromuscular blockers • The recognition and management of shock • Renal failure, diagnosis, treatment and prevention • Pediatric burns • Pain and sedation in the critically ill

May 7, 1994

Symposium to discuss the adoption of health care reforms • Rural surgery and surgeons: American College of Surgeons' Perspective

ACCREDITATION

As an organization accredited for Continuing Medical Education, the Iowa Methodist Medical Center certifies that this offering meets the criteria for Category I credit toward AMA Physician's Recognition Award, provided it is used and completed as designed:

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Strong tradition, great accomplishments

Several months ago I came upon the advertisement reproduced here. In 1918 the University of Iowa College of Medicine regularly advertised in the *Journal of the Iowa Medical Society*. In its 48th year, the College of Medicine offered the amenities recited in this advertisement.

The requirements for admission were not much different than today. Postgraduate courses were offered; small group instruction in clinical work was emphasized.

However, all this was offered at an incredible tuition of $85 per year ($15 more per year for non-resident students.)

This got me wondering what new discoveries in medicine occurred during that era. Garrison's *History of Medicine* provided a fine chronology of the time. World War I came to an end in 1918. Postwar years often provide stimuli to research and advancement. Numerous medical facilities were founded throughout the world.

Following is a partial list of other landmark events in the world of medicine during the post-World War I era:

1918

•Fahraeus introduced the erythrocyte sedimentation test. •Dandy evolved the technique of air ventriculography. •Sachs-Georgi introduced the flocculation test in syphilis.

1919

•Mellanby produced experimental rickets and treated them with cod liver oil. •Kolle and Ritz treated experimental syphilis in rabbits with bismuth. •Dale and Laidlaw investigated histamine shock.

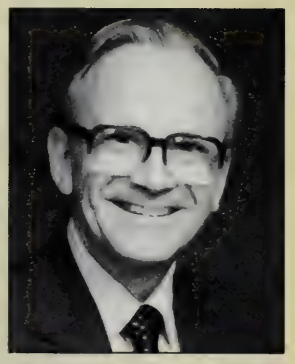
1920

•Noguchi discovered Leptospira icterohemorrhagiae. •Rubin demonstrated inflation of Fallopian tubes in sterility. •National Child Health Council of the U.S. organized.

1921

•Banting and Best isolated insulin. •A.F. Hess treated rickets by exposure to sunlight. •General use of iodine as an antiseptic (Pregl's solution). •Langley published a book on the autonomic system.

Graduates of the University of Iowa College of Medicine of this era have undoubtedly gone before us, but if any are still living it would be nice to know. As we dedicate this month's *Iowa Medicine* to the UI College of Medicine, we honor those students and faculty of the past and present. Tradition is strong and accomplishments great. Medical knowledge strides forward because of the caliber of people at the University of Iowa. IM



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CME through teaching

The growing interest in educating primary care physicians necessitates new teaching paradigms in medical schools. The historic clinical base for medical school teaching has been the academic referral center with which most medical schools are affiliated. These medical centers have developed sophisticated health care capacities, with subspecialty physicians and other related health care professionals to provide tertiary level care.

Residency programs and medical student teaching have flourished in these settings, but there has been a dramatic change in the types of patients occupying the beds at these centers.

Gone are most patients admitted for diagnostic evaluations. These assessments, even those involving multiple, complex laboratory and radiological examinations, are done in the outpatient setting. Gone are many patients receiving less than intensive care. Such patients now are likely to be hospitalized in larger community hospitals.

Therefore most medical schools are shifting an increasing amount of teaching into outpatient or clinic settings. Where primary health care is provided within the academic medical center, students learn about prevention and management of common chronic conditions. In most medical schools, however, it is necessary to teach primary care in community clinics and office practices.

This necessity has resulted in recruitment of practicing physicians to mentor and to participate in the education of students. The community-based experiences can vary from observation, such as in the Medical Education Community Opportunity (MECO) program of the University of Iowa in which approximately 85 students will participate during the summer of 1994. Once history taking and physical assessment skills are acquired, students more actively participate as part of the health care team during their clinical education years.

Such clerkships can occur in many settings with a committed clinical teacher as long as educational objectives and appropriate evaluation are structured. The University's Department of Family Practice, for example, has approximately 100 community physician preceptors for third year student clerkships.

Preceptors learn to focus their own CME to fulfill the responsibilities of teaching.

The U of I clinical teaching faculty value their educational role as much for the challenge to maintain contemporary patient care skills as for the mentoring contact with students. The need to respond to the spontaneous question of a third year student provides considerable motivation to remain current. Preceptors learn to focus their own CME to fulfill both the responsibilities of patient care and their teaching.

Continuing education accreditation bodies have long recognized the importance of teaching in maintaining practice skills and have established a category for that credit, now included within Category 2 of the AMA's Physician Recognition Award. IM



Richard Nelson, MD

Classified Advertising

Emergency Medicine Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Marshalltown, Iowa—Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Numerous other Iowa locales. ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

Immediate Opening—One internist or family practitioner (internist preferred) at a 200-bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $74,640.00. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644. Telephone: 319/334-2583. An Equal Opportunity/Affirmative Action Employer.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

BC Family Physician—Wanted for 50% job share at 17-physician multispecialty clinic in Marshall, Minnesota. Full range of family practice in delightful community of 12,000 with excellent city hospital and Southwest State University. Contact Vince LaPorte, MD, 507/532-9631 MWF or 507/532-5022 Tuesday or Thursday.

Cedar Rapids, Iowa—Established all emergency medicine boarded group seeking BC/BP emergency physician to join 6-member group. Brand new ED, highly trained staff, approximately 35,000 ED census. Will be double coverage with 8-hour shifts. Competitive compensation package. Contact: 319/398-6047 or send CV to Mercy Trauma Physicians P.C., 701 10th SE, Cedar Rapids, Iowa 52403-1251.

Family Practice, Carroll, Iowa—Outstanding professional opportunities for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197, or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Explore Minnesota and Primary Care—With North Memorial Medical Center primary care network. Openings are available for: family practice, internal medicine and OB/GYN physicians and physician assistants. These opportunities offer stability without sacrificing autonomy. Single and multispecialty groups in urban, suburban and semi-rural settings. Teaching opportunities with North/University of Minnesota residency program. Competitive compensation structures and flexible schedules with independent or hospital owned group practices. Immediate access to Minneapolis/St. Paul attractions. Central to Minnesota's abundant lakes country. If you are BC/BE send your CV or call in confidence to North Medical Programs, North Memorial Medical Center, 3300 Oakdale Avenue North, Robbinsdale, Minnesota 55422-2900. Nationwide and Canada 1-800/275-4790.

Internal Medicine, Family Practice and OB/GYN Practice Opportunities—Rural lake country community is seeking the above practitioners to join an active 12-physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquires to Lake Region Clinic, PC, Attn: Joel Rotvold, P.O. Box 1100, Devils Lake, North Dakota 58301 or call collect at 701/662-2157 for further information.

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Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Emergency Medicine
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Immediate opportunity for primary care trained or experienced emergency physician. Spencer Municipal Hospital is a progressive 131-bed hospital with a staff of 30 physicians representing major specialties. 8400 volume/24-hour shifts. Spencer is a community where country charm and modern lifestyles go hand in hand. Vacation year round on the Iowa Great Lakes of Lake Okoboji and Spirit Lake. Spencer also has a variety of restaurants and shops, much more than typically found in a community of 12,000. Highly rated award winning schools make Spencer an excellent place to raise a family. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Opportunities Available—Family practice, emergency medicine, internal medicine, locums, ob/gyn, occupational medicine, pediatrics, urgent care opportunities available in Minneapolis/St. Paul and leading communities within a 150 mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, Minnesota 55430; 1-800/248-4921 or 612/574-7627.

Family Practice Physicians—Gundersen Clinic is a 300-member multispecialty group practice which is adjacent to Lutheran Hospital, La Crosse, Wisconsin, a 402-bed tertiary care facility. As a result of our continued growth and a 100-year tradition of exceptional medical care, we are seeking family practice physicians with interest in routine obstetrics. Currently, we are recruiting family practice physicians to serve in our main La Crosse clinic, plus each of these branch clinics: 1) Gundersen Clinic, Decorah, Iowa; 2) Gundersen-Farrell Clinic, Prairie du Chien, Wisconsin; and 3) Gundersen-Mubarak Clinic, Tomah, Wisconsin. Our clinics provide specialized and primary care to nearly 70,000 families through over 745,000 visits per year. Our family practice group is the second largest department in the Gundersen system. Call groups vary in size depending on the community. The successful candidates will enjoy full administrative and technical support while being allowed to exercise your medical judgement without intervention. You will be encouraged to develop your practice based upon the needs of the community. In addition, we also offer extensive opportunities for continued education, and to perform clinical research. For more information, including salary and benefits, send your CV or call Tim Skinner toll-free 800/362-9567 or call collect 608/782-7300, ext. 6673. Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601. An equal opportunity employer.

Emergency Medicine, Council Bluffs, Iowa—Opening available for qualified physician to join group of emergency physicians. Training and/or certification in primary care specialty or emergency medicine. Flexible scheduling. Newly remodeled emergency department. Enjoy a rural and urban atmosphere. Write Bluffs Emergency Care Services, P.C., 933 East Pierce Street, Council Bluffs, Iowa 51503; 712/328-6111.

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Iowa City, Emergency Medicine—Mercy Hospital is seeking a primary care physician (EM, FP, IM, or G. Sur) with ER experience for a weekend emergency department position. Good backup, paid malpractice, competitive salary and a pleasant university community make this an attractive opportunity. Send CV to C. Huss, MD, Emergency Care Unit, Mercy Hospital, 500 Market Street, Iowa City, Iowa 52245; phone 319/339-3600; fax 319/339-3786.

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Emergency Medicine
Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

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(Continued next page)

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Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 55-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President or Dr. B. C. McGregor, President, at 507/625-1811 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

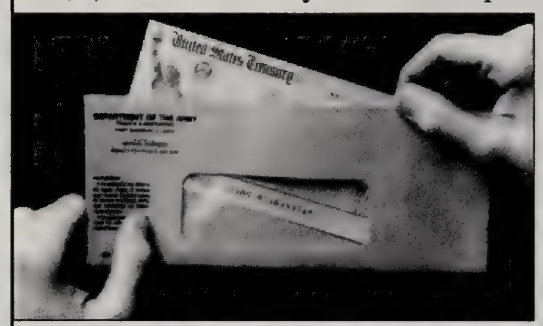
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Depression Throughout the Lifespan: Psychopharmacologic & Psychotherapeutic Strategies featuring Drs. Steven Dubovsky, Taylor Segraves, George Zubenko and Walter Menninger. June 24-25. Location: Kansas City. CE credit: 12 hours. Cost: $195. Contact: Menninger Continuing Education, 800/288-7377.

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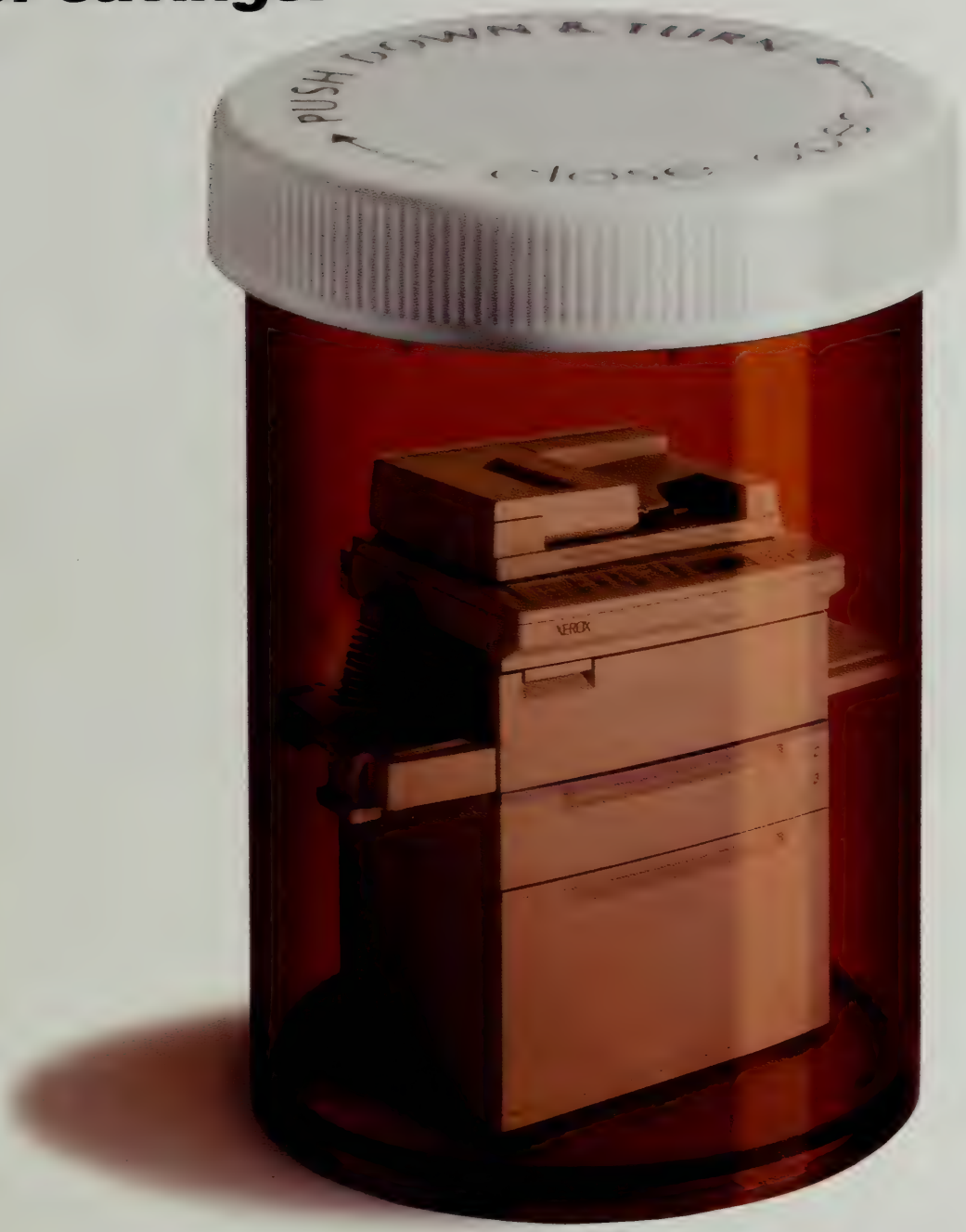
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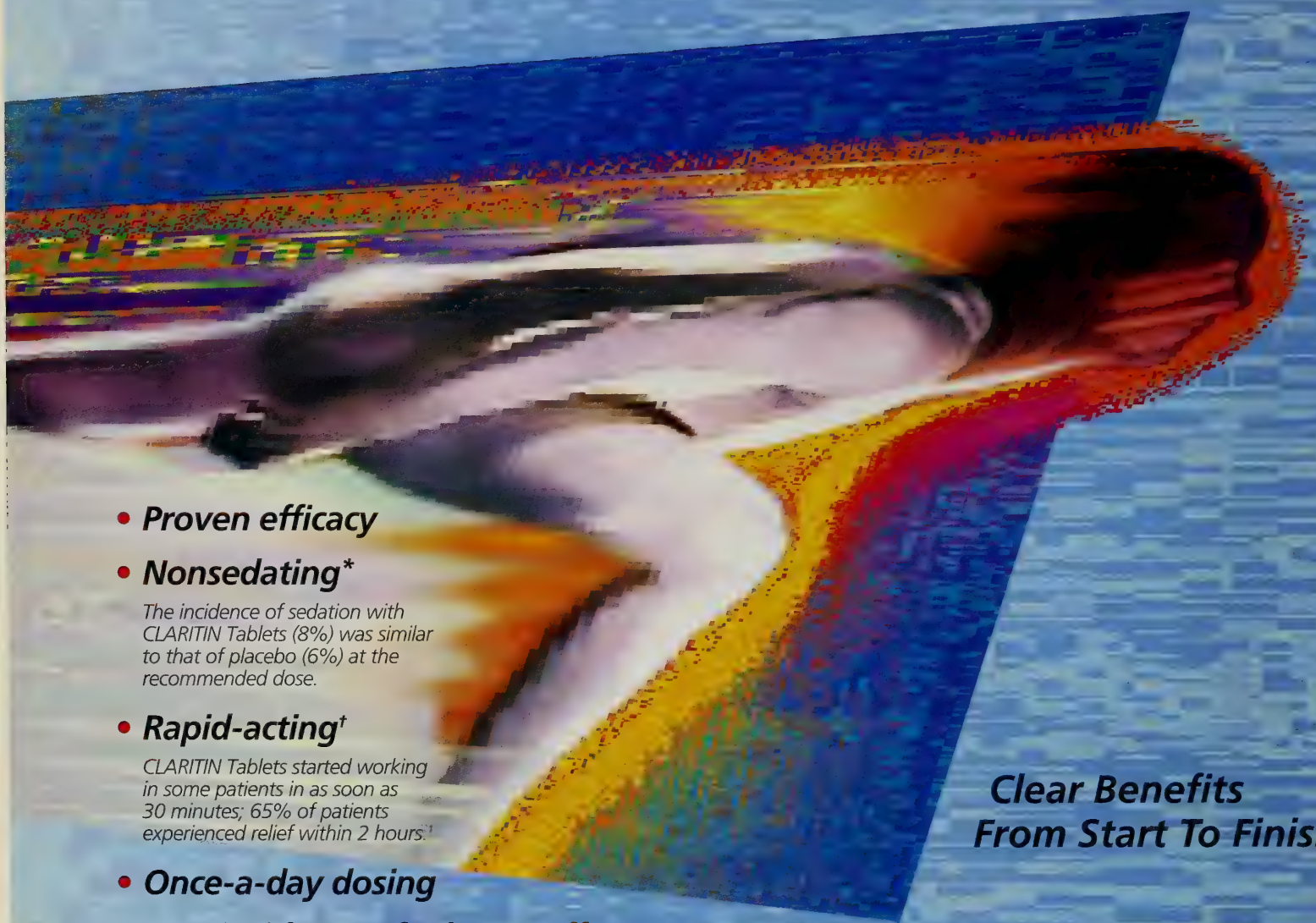
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PRECAUTIONS
General: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTED ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLED ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System Arthralgia, myalgia
Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis
Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System Urinary discoloration, altered micturition

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema; abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis; alopecia; seizures; breast enlargement; erythema multiforme; and anaphylaxis

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys

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Reference

1. Bédard P-M, Del Carpio J, Drouin MA, et al. Onset of action of loratadine and placebo and other efficacy variables in patients with seasonal allergic rhinitis. Clin Ther. 1992;14:268-275.

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Three absolutes are worth repeating

Spring is here, income taxes have been paid, the IMS House of Delegates is history and, in Washington, Congress is debating health system reform. The work of the AMA and organized medicine has been very important. However, an even bigger job remains.

Everyone — and that includes you and me — must play an active role to ensure passage of a health system reform bill that is good for our patients and for physicians.

In my inaugural president's speech in April of last year, I spoke of three absolutes. They are just as important now as they were then. Those absolutes are: (1) put patients first; (2) stay involved; and (3) stay united as a profession.

It is disconcerting when we hear the American Academy of Family Physicians, the American College of Surgeons and the AMA appear to march to different drummers. I sincerely believe that the AMA's Health Access America is the best plan before Congress. It puts patients first and is a plan we should all support. The AMA reform proposal is intended to:

I sincerely believe the AMA's Health Access America is the best plan before Congress.

- Achieve universal coverage for all Americans through shared responsibility of employers, individuals and government
- Strengthen the voice of physicians in clinical judgment and decision-making to balance increasing corporate domination of health care
- Slow the rate of growth in health spending through competition in the marketplace
- Effect major professional liability reform to reduce the inappropriate cost of defensive medicine and liability insurance premiums
- Provide price and quality information so patients can make informed decisions
- Create a more efficient, streamlined and coordinated health care system
- Assure that all Americans can choose health plans and physicians

In March, the AMA called all state and specialty society leadership to Washington, DC in an effort to show Congress that physicians are indeed united. In conjunction with this event, a full-page ad appeared in newspapers across the country, with every state medical society and 64 specialty societies urging Congress to adopt the principles I just outlined.

The AMA is trying hard to maintain physician unity. Organized medicine in general — the AMA and the IMS in particular — will stay involved. However, you must stay involved, too. This is going to be a long haul as health system reform trundles through Congress and then through the rule-making process. Throughout this time, we must stay united.

The IMS is also working hard to maintain physician unity. The Forum on Health System Reform at the April House of Delegates was an attempt to hear different ideas so we might speak with one voice. For the sake of our patients and medicine in Iowa, let's stay involved and unified on the state level as well.

This is my final president's column. It has been an honor to serve you for the past year and I thank you for the privilege. IM



JOHN ANDERSON, MD

IMS Update

IMS president-elect, officers chosen

Joseph Hall, MD, a Des Moines radiologist, was elected president-elect of the Iowa Medical Society on Sunday, April 17 at the Society's annual meeting at the Savery Hotel. Dr. Hall has served the IMS in many capacities, including as chairman of the IMS Board of Trustees. He will take office in April of 1995.

The following physicians were also elected to office April 17: Vice president — **Siroos Shirazi, MD**, Iowa City; Trustee — **John Brinkman, MD**, Mason City; Speaker, House of Delegates — **Donald Kahle, MD**, Dubuque; Vice Speaker, House of Delegates — **Tom Throckmorton, MD**, Spencer; AMA delegates — **Clarence Denser, Jr., MD**, Des Moines; **Bruce Trimble, MD**, Mason City; **Donald Young, MD**, Solon.

Six District Councilors were also chosen during the IMS House of Delegates: **Engene Kerns, MD**, Davenport (District III); **Steven Erickson, MD**, Cedar Falls (District VII); **Leo Milleman, MD**, Ames (District VIII); **John Fernandez, MD**, Council Bluffs (District XII); **Kathryn Opheim, MD**, Sioux City (District XV); and **Michael Disbro, MD**, Des Moines (District X special election).

At the conclusion of the House of Delegates, **James White, MD**, a Dubuque otolaryngologist, was installed as 1994-95 IMS president.

IMS Membership Directory verification

In early June, IMS member physicians will receive a letter which will verify their office addresses, phone and fax numbers, etc. for the 1994-95 IMS Membership Directory. The directory will be distributed next fall to all member physicians, hopsitals, chambers of commerce, etc.

Please watch for your verification letter and return it promptly to IMS headquarters. This is esssential if the new directory is to contain the correct information about your practice.

In addition, member physicians may advertise their practices in a special section of the directory. This advertising section is intended for reference use by member physicians making referrals and by the general public needing medical services. For details on how to place an ad in the IMS Membership Directory, call Jane Nieland or Bev Corron at IMS headquarters, 515/223-1401 or 800/747-3070. If you placed an advertisement in last year's directory, you will receive a renewal form soon.

Changes in IMG licensing requirements

The Iowa Board of Medical Examiners (BME) has adopted a revised rule which will extend eligibility for an Iowa license to certain "highly-trained and experienced" International Medical School Graduates (IMGs).

To be eligible for permanent licensure under the revised rule, an IMG must (1) hold a valid certificate issued by the Educational Commission for Foreign Medical Graduates; or (2) successfully complete an approved Fifth Pathway Program; or (3) provide documentation of five years of practice as permanent licensee of the US or Canada without restrictions, successful

AT A GLANCE

The 1994 Iowa Family Practice Opportunities Fair will be held Saturday, August 27 at the Savery Hotel and Des Moines Convention Center. The event is cosponsored by the Iowa Medical Society and the Iowa Academy of Family Physicians. For more information call 319/335-8618.

The IMS Board of Trustees has approved a recommendation that the IMS encourage member physicians to create physician organizations (POs) to pursue managed care contracting opportunities. Check this month's Health System Reform *section for more details.*

The Iowa Optometric Association has filed a lawsuit against the Iowa Academy of Ophthalmology for alleged violation of federal antitrust laws.

Specialty Society Update

The Iowa Psychiatric Society's Fall Meeting will be October 14-15 at the Holiday Inn, Iowa City. The IPS continues to coordinate a legislative coalition which will attempt to affect mental health benefits in health reform legislation.

Jack McDermott, administrator of Orthopaedic Surgery Associates in Davenport, has been named the Iowa Medical Society's Outstanding Medical Administrator of the Year. Mr. McDermott received his award at the IMS Annual Banquet April 16.

The American College of Surgeons has issued a clarification of testimony given on Capitol Hill in February. In the new statement, the ACOS denies media reports which said the College endorsed a single payer system. Check the Health System Reform section on page 198 for more details.

The Iowa Vascular Surgery Society spring meeting is being rescheduled for May or June.

Focus on IMS Alliance

Linda Miller of Davenport was chosen President-elect of the Iowa Medical Society Alliance at the IMSA Annual Meeting April 15-16. Mrs. Miller will take office in April of 1995.

Other 1994-95 IMSA officers elected were: First Vice President — Karen Messamer, Oskaloosa; Second Vice President — Bonnie Zittergruen, West Des Moines; Secretary — Dianna Moeller, Mason City; and Treasurer — Maureen Lyons, Marshalltown.

Contributed by Barbara Bell, IMSA president

completion of three years of postgraduate training and passing scores on certain examinations. The revised rule went into effect in March. For more details, contact Ann Martino, Ph.D., executive director of the Iowa BME.

AMA membership increases in Iowa

For the eighteenth consecutive year, the number of IMS members who also belong to the AMA has increased. This achievement was recognized at the AMA National Leadership Conference when Lonnie Bristow, MD, chairman of the AMA Board of Trustees, presented an award plaque to John Anderson, MD, IMS president.

Golf Passport helps Iowa kids

The Caring Program for Children is offering a 1994 Golf Passport. The $20 passport offers free play or discounted rounds at courses including Panorama, Amana, Finkbine in Iowa City, Brooks at Okoboji and Red Carpet Golf Club in Waterloo. There are also six participating courses in the Des Moines area.

The Caring Program for children provides primary and preventive health care to uninsured children across Iowa. Currently, the program serves 3,000 uninsured children whose families do not qualify for Medicaid.

To order a Golf Passport, send a check to the Caring Foundation, Golf Passport, 636 Grand Avenue, Station 150, Des Moines, Iowa 50309-9984 or call 800/543-4483.

AMA supports video game rating

The AMA has issued a statement supporting the 1994 Video Game Rating Act as a way to reduce t.v. violence seen by children. IM

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Health System Reform

Iowa physicians air views at IMS forum

There may be variations in the goals of certain specialties, but the need for unity among physicians was acknowledged repeatedly at the Iowa Medical Society's Forum on Health System Reform Saturday, April 16.

"Every other country that has had health system reform has done it by driving wedges between doctors," Dr. Nancy Dickey, AMA trustee, told an audience of about 150 physicians. "The process isn't over yet. The major conversations are just beginning."

Dr. Dickey — one of six panelists called together to discuss health system reform and take questions from audience members — focused on the national scene. She said movement on reform is "continuous" and cautioned that the obituaries being written for the Clinton plan may be premature.

William Eversmann, Jr., MD, a Cedar Rapids hand surgeon and member of the Governor's Health Reform Council, said the Council's bill died in the Legislature when "labor unions, trial lawyers and certain consumer groups trashed the bill to the point that it was unacceptable."

Dr. Laine Dvorak of Humboldt, representing the Iowa Academy of Family Physicians, said the Academy wants "everyone to have a primary care physician to coordinate their care and parity between rural and urban systems."

"Everyone should have a primary care physician to coordinate their care," he said.

Dr. Jerold Woodhead, Iowa City, representing the American Academy of Pediatrics, Iowa Chapter, said the AAP is concentrating on the fact children are one-third of the uninsured.

"The Clinton Bill isn't perfect, but it contains more of the benefits children need than any other plan," he said. "The AAP agrees with almost all of the AMA's plan, but it doesn't deal adequately with children."

Dr. Luke Faber, representing the American College of Surgeons, refuted news reports about the ACS testimony before a congressional committee, saying "the College has not approved any plan. Like everyone, we're waiting." (Further details about the ACS testimony can be found in this section.)

Dr. Faber said the ACS priorities are universal coverage, freedom of choice and "fees for what you do, not what you don't do."

He also said reform should be incremental. "This shouldn't be like Moses coming down from the mountain, looking back at the clouds and asking 'All 10 at the same time?'."

Dr. Steven Craig of Des Moines, representing the American Society of Internal Medicine, said internists favor "negotiated spending targets rather than budget caps."

"Like other specialties, we're concerned about antitrust relief, malpractice reform and rebuilding primary care training," he said. "We have pointed out our differences with the AMA plan in a friendly and workable fashion."

A lively question and answer period followed the presentations. Several questions focused on the "gatekeeper" concept which is a feature of some reform plans, with some physicians questioning whether primary care physicians are trained to perform all the procedures they will be required to perform.

Dr. Dickey, who is a family physician in Texas, said the intent of primary care physicians is not "to shut off the supply of patients to specialists" but to be coordinators of care.

"Some physicians will need training to learn new skills and to recognize their limitations and the need to refer," added Dr. Craig.

There was also discussion of whether "any willing provider" should be the rule for managed care, an issue which is causing considerable

AT A GLANCE

Most Americans are confused by the myriad of health system reform proposals, but USA Today *says they don't need to keep them all straight because "none of these plans will be adopted in anything like current form."*

A March Wall Street Journal*/NBC poll found Americans have greater confidence in the AMA's health reform proposal (41%)than in the Clinton plan (39%). The poll of 1,500 Americans found people thought it was very important to get information on reform from their doctors (54%) in comparison to the newspaper (46%).*

According to a study by the Employment Policies Institute, the employer mandates in the Clinton health reform plan could cost between 780,000 and 2.1 million jobs, predominantly among low-income workers.

WORTH REPEATING

"I told Mrs. Clinton, 'If you and Sheila can agree on a plan, I'll vote for it'."

Senator Bob Dole, referring to his chief of staff Sheila Burke. Ms. Burke, highly respected on both sides of the aisle, has been dubbed 'Health reform's Other Woman'.

controversy among physicians. "This concept doesn't sell in Washington. There, it's 'any qualified provider'," Dr. Dickey said.

One physician at the meeting decried the fact that independent family practitioners are a dying breed because "when hospitals buy up all the family physicians, they have all the power."

Dole, Grassley speak on health care

Senators Bob Dole and Chuck Grassley say Congress will pass some kind of a health system reform bill, but it may not be as comprehensive as some might wish.

The two Republican senators made their remarks at a recent Des Moines town meeting which was the kick-off event for 12 town meetings Grassley plans to hold across the state.

"I will vote for any legislation that improves the situation," Grassley told a large audience. "I'm not looking for all-or-nothing."

Dole is on the Senate Finance Committee which will ultimately determine what action is taken toward health system reform. Dole credited the President and Mrs. Clinton with "keeping this issue on the agenda" and said he hopes for bi-partisan decisions from the committee.

"No one has the votes to pass anything right now. When Congress does pass a bill, the President could veto it if he doesn't like it or thinks it doesn't go far enough," Dole commented. "But, I don't think he'll do that."

Dole believes employer and individual mandates, price controls and mandated alliances contained in various proposals will not survive in Congress. Both Dole and Grassley said there are concerns about how managed competition will work in rural areas and both said price controls are not the way to deal with gouging.

Senator Dole commented on the number of physicians he has seen attending meetings on health system reform.

"They're concerned about how they're going to treat patients," he said. "I believe that there will always be physicians who practice fee-for-service and there probably should be."

Both Dole and Grassley cautioned against moving too fast on health system reform.

"We want to see how a comprehensive plan will work before tinkering with Medicare," Grassley said. "Medicare will be rolled into a program if we have a good one going."

Governor Branstad, also part of the panel, said there is widespread support for malpractice reform "except for a few trial lawyers".

Board approves PO project

The Iowa Medical Society will embark on a project to educate Iowa physicians about POs and PHOs and identify consultants to which physicians can be referred when they need assistance in pursuing managed care contracting opportunities and other cooperative ventures.

Board approval of the statewide educational project came after an ad hoc committee studied the feasibility of creating a statewide IPA. Instead, the committee recommended the IMS assist Iowa physicians in evaluating options appropriate for their community.

The IMS will also identify all physician IPAs and POs in Iowa and schedule regular meetings for their representatives. Watch future issues of *Iowa Medicine* for more details on this project.

Further clarification from ACS

The American College of Surgeons has sent letters to the AMA's *AM News* and to the *New York Times* taking exception to "a number of errors" in coverage of ACS testimony before a Congressional subcommittee hearing.

At the hearing, Dr. David Murray of the ACS Board of Regents, made statements regarding a single payer system which the AMA and the media reported as "Surgeons back single payer". Dr. Murray said single-payer approaches "probably provide the best assurances patients will be able to seek care from any doctor" but the ACS says this was not an endorsement.

"The ACS has not issued any formal statement with regard to endorsement of a single-payer plan," said the letter. The ACS expressed disappointment that, "at a time when the AMA is espousing unity, it chooses to headline an article erroneously simply to increase the effect". IM

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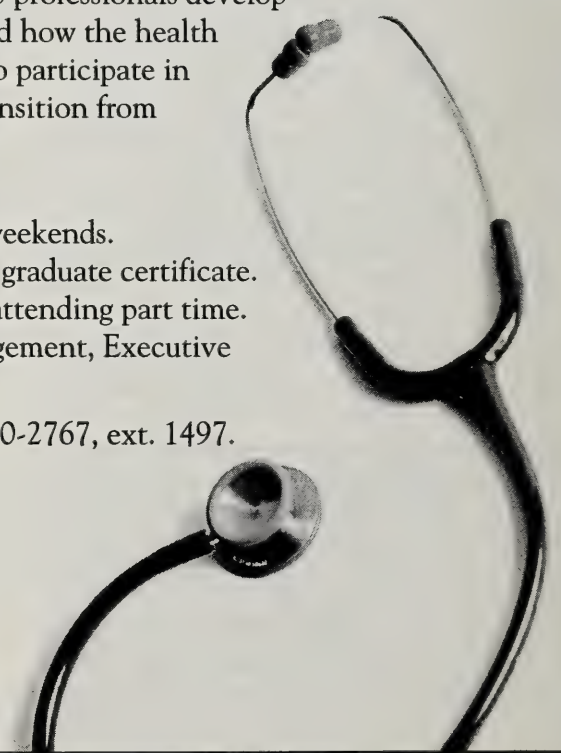
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Legislative Affairs

Free political leadership seminar

The IMS will sponsor a free seminar entitled **Political Leadership in the 1990s** on Wednesday, June 8 at the University Park Holiday Inn, West Des Moines. It is open to all IMS physicians and their spouses.

The seminar will provide information on public speaking, writing letters to the editor and mobilizing the medical community. It will help you get ready to speak for your candidate in the medical community and to speak for the medical community with your neighbors.

To register, call Lyn Durante at the IMS, 800/747-3070 or 515/223-1401.

Update on legislative issues

Another legislative session is drawing to a close although as of press time several key issues had not been resolved. A report on these issues will appear in the June *Iowa Medicine*. Following is an update on a variety of issues.

Health system reform

The Senate-passed health system reform bill will not be considered by the House. The bill would have caused significant disruption in the health insurance market and could have resulted in more uninsured Iowans. One of the most noteworthy provisions of that bill would have required managed care plans to provide direct access to a wide variety of practitioners while limiting access to specialist physicians.

SF 2282, relating to insurance regulation, has been amended to require employers to offer access to health benefits, although they would not have to pay for those benefits. The amendment also requires community rating for the basic and standard benefit plans provided for under small group insurance laws. SF 2282 has been approved and sent to the governor.

HF 2422 by the House Appropriations Committee contains a package of incentives for rural health care. HF 2422 establishes a Center for Rural Health and Primary Care within the Iowa Department of Public Health. This is an expansion of the existing office of rural health. The Center will encourage collaborative local efforts to adopt local health services plans, coordinate services relating to rural occupational health issues, and establish a recruitment and retention program, a primary care provider loan repayment program, a community scholarship program and a community grant program.

The bill also requires the Iowa Department of Public Health to establish area health education centers (AHECs) in cooperation with the University of Iowa College of Medicine, the University of Osteopathic Medicine and Health Sciences and other educational institutions. The AHECs are intended to provide education opportunities for primary care providers, consultation and access to medical libraries and resources. HF 2422 has passed both houses in the same form and is being sent to the governor for his consideration.

Access to state fiber optic network

It appears access for physicians' clinics and hospitals to the state fiber optic network for the purpose of telemedicine will be approved this year although the process has not been completed. A conference committee report on SF 2089, relating to the network's governing structure, includes language allowing such access. Both the House and Senate have approved the report.

CHMIS

The Community Health Management Information System bill, SF 2069, has passed the legislature and been signed by the governor. The bill sets up an electronic system of claims processing and data collection using information from the claims form. A uniform claims format will be required to be used by all insurers doing business in Iowa.

Tobacco

There has been a lot of activity on tobacco

continued next page

AT A GLANCE

A recent Wall Street Journal *story reports the tobacco lobby is finding its influence waning in Congress as health system reform moves forward. In a related development, Philip Morris has filed a $10 billion libel suit against ABC, charging the network falsely accused the tobacco industry of manipulating the nicotine level in cigarettes.*

The new Health Care Liability Alliance received publicity in the Washington Times *recently. The new coalition includes the AMA and other business and industry organizations pushing for significant reforms.*

Legislative Affairs

continued

issues this year, generated by the IMS/Tobacco Free Coalition initiative. The IMS/Tobacco Free Coalition bill was approved by the Senate Human Resources Committee in a slightly modified form, but as a result of intense lobbying by the tobacco industry, Senate leadership failed to bring the bill up for debate prior to legislative funnel deadlines.

However, the House of Representatives approved an amendment by Representative Phil Brammer which was identical to the committee-approved coalition bill. The amendment was attached to the Health and Human Rights Appropriations bill. The Senate Appropriations Committee approved an amendment to the House bill to remove the anti-tobacco sections. The fight then went to the full Senate.

The intent of the amendment was to protect the public from criminals who may be leaving prison.

The coalition came within four votes of defeating the committee amendment. Several supporters of the bill were convinced to vote against the coalition position on the grounds that if amendments to statutes are allowed to appropriations bills the legislative process will bog down. Senators made commitments during debate to find another bill which could be amended to include portions of the coalition proposal. No further action had been taken as of press time.

This issue has remained alive in spite of strong lobbying by the tobacco industry because of grass roots contacts by physicians and volunteers for the American Lung Association of Iowa, the American Heart Association and the American Cancer Society. Your efforts this year have helped lay the groundwork for future legislation, by letting legislators and candidates know that these issues are important to their constituents.

If you would like more information or IMS position papers on any legislative issue, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

The Tobacco Free Coalition proposal would have extended the Clean Indoor Air Act to all restaurants but would have allowed restaurants with seating capacity of under 50 to designate their entire premises as a smoking area if they post signs to that effect.

The bill also would eliminate the restriction on local governments passing non-smoking ordinances that are stricter than state law, require greater separation between smoking and non-smoking areas and make the Iowa Department of Public Health responsible for enforcing Iowa's Clean Indoor Air Act.

Nurse practitioner prescribing

SF 2053 will allow nurse practitioners to prescribe controlled substances and extends prescribing privileges to nurse anesthetists. A committee amendment was adopted providing that nurse practitioner prescribing rules would be done by the Board of Nursing in consultation with the Board of Medical Examiners and the Board of Pharmacy Examiners. The bill as introduced would have removed this joint rulemaking. In spite of strong efforts by anesthesiologists in particular, the bill has been approved by both houses and will go to the governor for consideration.

HIV notification

SF 2149 has been amended by the Senate to allow state and county medical examiners and deputies to notify immediate family members and partners of a deceased person that the deceased person tested positive for HIV. This may only be done as part of the medical examiner's official duties. The IMS expects to do a more comprehensive review of Iowa's laws relating to HIV/AIDS this summer and fall.

Mandatory physician assistant coverage

SF 2211 would require health insurance companies to provide payment for services provided by a physician assistant within the PA's scope of practice if the same services are covered when provided by a physician. This bill has passed the Senate but had not been debated by the House as of press time. Amendments have been filed in the House to extend the same mandate to services provided by nurse practitioners, nurse anesthetists and podiatrists.

Juvenile justice bill

SF 2319, the juvenile justice bill, contains an amendment added in the House providing that "sexually violent predators" could be removed from the state correctional system and sent to a mental health institute until they are no longer a danger to society.

The intent of the amendment was to protect the public from criminals who may be leaving prison, but the language of the amendment appears to allow violent crinminals to transfer during the course of serving a sentence from a correctional institution such as the one at Fort Madison to a mental health institute or other facility operated by the Department of Human Services. Enactment of this portion of the bill will be delayed until 1995. The bill passed and has gone to the governor. IM

Medical Economics

IFMC election results

According to the Iowa Foundation for Medical Care, eight directors taking office immediately for three-year terms are:

David Thomas, MD, Marshalltown (District III); Larry Goetz, MD, Creston (District V); Brian Ford, MD, Orleans (District VI); David Zuehlke, MD, Sioux City (Woodbury County); John Brehm, MD, Dubuque (Dubuque County); Robert Reiter, MD, Iowa City (Johnson County); Rick Kellenberger, DO, West Bend (DO representative outside Polk County); and Harlan Rosenberg, MD, Des Moines (Polk County).

New officers for the IFMC Board of Directors for 1994-95 are:

President	Karl Larsen, MD, Iowa City
First vice president	Koert Smith, MD, Burlington
Second Vice president	John Meyer, DO, Maquoketa
Secretary	Harlan Rosenberg, MD, Des Moines
Treasurer	John Brehm, MD, Dubuque
Past president	Kenneth Cearlock, MD, Cedar Rapids
At-large director	David Thomas, MD, Marshalltown
Comprehensive Review Committee Chair	R. Ried Boom, MD, Manchester
Long Term Care	Lanny Ward, Indianola
Business advisor	Thomas Morin, Newton
Ex officio member	Charles Jons, MD, Ames

In addition to election of officers, two revisions to the IFMC Articles and Bylaws have been approved. One resolution concerns physician membership, member voting procedures, some Board of Director requirements and a means for handling future revisions of IFMC Articles and Bylaws. Another revision concerns non-physician directors of IFMC committees.

Mental health managed care proposals

The Iowa Department of Human Services (DHS) has issued a request for proposals for implementation of a managed care mental health program.

Interested entities may respond to the DHS request with a letter of intent. The closing date for receiving proposals is May 6, 1994. The award will be issued May 27, with the contract to be implemented July 1, 1994.

Following is the DHS description of the Scope of Services of the proposed program:

Eligibility — Recipients in the program will be Supplemental Security Income (SSI) recipients who are blind or disabled but not including those age 65 or over.

Non-eligible — SSI recipients over age 65 (benefits will follow Medicare) and Medically Needy (the income spend down formula is too complicated for this program) are excluded due to coverage eligibility in other programs.

Services — Crisis counseling, family counseling, individual counseling and therapies; prescription drug management (drugs will be paid through the fee-for-service Medicaid program, but not through the managed care entity).

Exclusions — Medical services will be processed under the fee-for-service Medicaid benefit program; substance abuse services will only be managed under this program if secondary to a mental health diagnosis.

Contract specifics — Capitation amount for each recipient; single line HMO; mental health-related services only; HMO does not have to be licensed in Iowa, will not be under regulatory authority of the Iowa Division of Insurance; statewide implementation.

For more information, call Donna Bottorff at the IMS, 800/747-3070 or 515/223-1401.

Medicaid lock-in saves money

The Iowa Department of Human Services (DHS) says a Medicaid "lock-in" program saved over $1 million in 1993.

The DHS contracts with the Iowa Foundation for Medical Care (IFMC) to perform utilization review of health care to Medicaid

continued next page

AT A GLANCE

Iowa physicians are being commended for increases in compliance with EPSDT. Compliance is now 47%, which is considerably better than the former 13% compliance rate. The EPSDT compliance goal is 80%.

Based on a recent court ruling, health care providers can legally list the 2% Minnesota health care tax as a separate item on patients' bills. However, according to a recent issue of Minnesota Medicine, *plaintiffs in another pending court case allege that any pass-through of the tax to self-funded employee benefit plans violates federal law. Watch future issues of* Iowa Medicine *for updates on this clash of legal principles.*

Medical Economics

continued

recipients. Recipients are reviewed by IFMC to determine overuse or misuse of services.

The purpose of the recipient lock-in is to promote quality health care and prevent harmful practices such as duplication of service, drug abuse and possible drug interaction.

Lock-in is applied to an individual recipient for a minimum of 24 months. The recipient has the choice of designated providers. The primary care physician selected by the patient is contacted by IFMC before the restriction is imposed to determine if the physician is willing to treat the recipient.

Lock-in interviews done by IFMC nurse coordinators during 1993 saved about $1.1 million.

The lock-in primary care physician is responsible for providing or directing the recipient's care. The physician makes necessary referrals. Prescriptions will be reimbursed only if written or approved by the lock-in primary care physician. IFMC nurse coordinators held 529 lock-in interviews during 1993, saving about $1.1 million.

IFMC receives referrals from providers who suspect Medicaid recipients of overuse or misues. If you have concerns, contact Andi Sparks, manager of LTC review/education services, 800/383-1173 or 515/223-2937.

Iowa-Illinois Blues awarded contract

The Health Care Financing Administration (HCFA) has taken a stronger position with local contractors processing Medicare Part A and B claims and is refusing to renew contracts for a variety of reasons including high cost and poor performance. Non-renewals are occurring rapidly and without advance notice to providers.

Earlier this year, the Part B contract held by King County Blue Cross and Blue Shield in Seattle was not renewed due to high costs. The contract was awarded without competitive bid to AETNA, another contractor in that part of the country.

More recently, HCFA has appointed BCBS of Illinois as the contractor for the Michigan Medicare program. HCFA administrator Dr. Bruce Vladeck said the action was taken "because the Medicare program in Michigan requires stronger management of payment safeguards and internal controls as well as better service for beneficiaries and health care providers."

Within a span of five days, HCFA announced the non-renewal of the contract to BCBS of Michigan, awarding of the contract to BCBS of Illinois and approval to convert to the claims processing systems used by BCBS of Illinois.

In giving the contract to BCBS of Illinois, Dr. Vladeck noted, "The selection of BCBS of Illinois was based on a record of integrity, cost-effective performance, claims processing efficiency, ability to assume the workload and experience."

A merged BCBS of Iowa and Illinois becomes the largest Part A (hospital) contractor among the Blues plans at 13.7 million claims for 1994.

The combined Part B (physician) workload is 55.9 million claims. This is the second largest Part B volume, exceeded only by Pennsylvania Blue Shield at 74.6 million claims a year. The merged organization would serve 3.2 million beneficiaries.

It is important for physicians to understand the relative stability of local contractors. Changes of this magnitude will undoubtedly affect the health care providers in their areas.

CHMIS group to make recommendations

The Community Health Management Information System (CHMIS) proposal is now law after being signed by Governor Branstad.

The CHMIS Data Advisory Task Force is meeting with the goal of identifying appropriate methods and technologies to collect data from hospitals and physicians. The group is looking at several vendors that can fulfill the tasks assigned to a central repository by the CHMIS legislation.

Physicians serving on the task force are Dale Andringa, MD; Louis Bannitt, MD; Kevin Cunningham, MD; Ron Grooters, MD; Jim Turner, MD; and Stephen Vanourney, MD.

The task force has implemented three subgroups, including one which will study DRG outcomes indicators. This sub-group has these additional members: Bruce Hardy, MD; Karl Larsen, MD; Tom Evans, MD; George Xahelles, MD; Ron Rossing, MD; and Robert Reiter, MD.

This sub-group will make recommendations to the CHMIS Data Task Force in June.

In the first phase of CHMIS implementation in 1996, it is necessary to develop a statewide network through which claims for all physician and hospital services can be submitted electronically. The format will be uniform, using the UB-92 and HCFA-1500.

If you have any questions regarding the CHMIS Task Force, call Donna Bottorff at the IMS, 515/223-1401 or 800/747-3070. IM

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

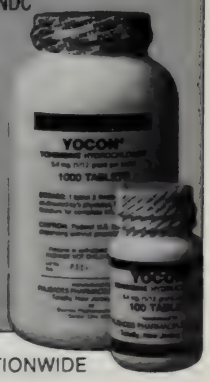
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Practice Management

Advice on retirement planning

Editor's note: This article was provided by Jerry Foster, president of Retirement and Investment Advisors, Inc. in West Des Moines.

Retirement planning requires an early start, though retirement savings may have to be delayed or reduced if you are saving for your child's education.

It is critical to establish objectives in retirement planning. Ask yourself some basic questions: When do I want to retire? Will I work part time? Will there be income sources other than my investment portfolio? What will my needs be in today's dollars? What inflation factor should I plan for?

A realistic understanding of inflation is important. For example, in 25 years — assuming an annual inflation rate of 4% — $1,000 will buy what $360 buys today. From 1967 to 1992, the purchasing power of the dollar shrank to 18 cents. If you don't plan for this reality, your retirement lifestyle will be affected.

It is also very important to plan for an adequate number of retirement years. As the chart above illustrates, if you retire at age 55 or 60 and plan only for a 20-year period, you may be cutting yourself short.

Expected number of years in retirement

Expected retirement age or current age if already retired	For individual	For couples same age, at least one will live:
55	28 years	34 years
60	24	30
65	20	25
70	16	21
75	12	16

Source: T. Rowe Price Associates, based on IRS information.

This chart predicts how long you can expect to be retired.

After you answer the basic questions, the next step is planning a strategy for savings. It is a wise idea to maximize contributions into your retirement plan.

However, with new restrictions on how much can be contributed, it may be necessary to explore non-qualified planning techniques such as a private pension plan or a charitable remainder trust.

Systematic savings is a discipline that will pay off. A few dollars every month will accumulate a significant base for your retirement. Automatic withdrawals from your checking as

AT A GLANCE

By now, all IMS member physicians should have received a mailing regarding the new Airborne Express overnight delivery service available through IMS Services. The program offers a 40% savings over other services. (See the IMS Services ad on page 213.) If you want more information, call Sandy Nelson at IMS Services, 515/223-2816.

Looking for a coding seminar? IMS Services is sponsoring two seminars of interest in Cedar Rapids — one on ICD9 Coding on Wednesday, June 15 and one on CPT Coding on Thursday, June 16. For further details, call Barb Cannon or Sherry Johnson at IMS Services, 515/223-1401 or 800/747-3070.

Back by popular demand for the third time, attorney Kenneth Davis, Jr. will present a seminar on "Managed Care Contracting" Wednesday, May 18 at St. Luke's Hospital in Davenport.

Upcoming Workshops for You and Your Practice

Retirement . . . Plan Ahead	**Tuesday, May 3**	**Sioux City**
Office Safety & Compliance	**Tuesday, May 10**	**Ft. Dodge**
Upcoming HCFA Documentation Guidelines . . . Are You Ready?	**Wednesday, May 11 & Thursday, May 12**	**Davenport**
Can I Sell My Practice?	**Thursday, May 12**	**Davenport**
Health Insurance Overview	**Tuesday, May 17**	**West Des Moines**
Managed Care Contracting	**Wednesday, May 18**	**Davenport**
Retirement . . . Plan Ahead	**Thursday, May 19**	**Waterloo**
Health Insurance Overview	**Tuesday, May 24**	**Cedar Rapids**
Quality in the Medical Office	**Tuesday, June 14**	**Cedar Rapids**

For more information on these or any other seminar listed here, call Sherry Johnson or Barb Cannon at IMS Services, 515/223-2816 or 800/728-5398.

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Litigation stress

It may not be quantifiable but there is no denying that "litigation stress" takes an enormous toll on physicians sued for malpractice. As a physician-owned insurance company, MMIC understands the isolation, negative self-image and depression which physicians can feel. Physicians who are sued feel their personal integrity is under attack. To minimize litigation stress:

- Don't isolate yourself from family and friends.
- Talk with your spouse, friends and colleagues about how this is affecting you.
- Don't discuss details of the case with anyone but your spouse, defense attorney or insurance company representative.
- Learn about the litigation process and get involved in your defense. Educate your attorney.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

well as monthly contributions into your retirement plan create a forced savings plan.

Establishing an investment strategy is also very important. Time horizon is one of the first factors that must be considered. How long do you have until retirement? How much income will you need for your portfolio? The longer your time horizon, the more aggressive you can be with your investments.

The biggest mistake people make is not being aggressive enough. Studies have proven that 94% of a portfolio's performance is determined by asset allocation (having the right mix of investments). Only 6% is due to security selection and timing. The key is to create a portfolio diverse enough to minimize downside risk and maximize upside potential. This will require considerable effort, but it will pay off during your retirement years.

Everyone's situation is different and circumstances are constantly changing. Therefore, it is vitally important to constantly reassess your retirement plan and calculate the impact of all your decisions. IM

Reducing Taxes with Tax Credits

Q. I keep reading about tax credit programs and how effective they are at reducing taxes. Can you tell me more about them?

A. One of the most effective and frequently overlooked ways of reducing federal tax liability is the Low Income Housing Tax Credit (LIHTC). Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

Investors typically receive tax credits equal to approximately 150% of their investment spread out over 10 years. So a $5,000 investment would yield tax savings of approximately $750 per year for the next 10 years, for a total of 7, 500. Depending on factors such as income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using LIHTC.

In addition to the credit there is potential for cash flow distributions in many programs. Generally all cash flow paid to investors is completely sheltered from taxes as well. Finally, when the properties in the portfolio are sold, they may be sold at a profit. Again a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The dollars raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. It is important to note that these are not crime infested, graffiti covered intercity housing projects. They are primarily new construction, garden-style suburban and rural apartment buildings.

The alternative to using LIHTC is simply to pay your taxes. For that you get no liquidity, no return and your holding period is forever. By using credits, you redirect dollars that would have been used to pay taxes back into your pocket to add to your net worth. This is why these programs are so widely used by corporations and individuals.

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Newsmakers

AT A GLANCE

Dr. Peter Wallace, Iowa City pediatrician, was the recipient of the Physician Award for Community Service at the IMS Annual Banquet, Saturday evening, April 16. This award honors Dr. Wallace for providing outstanding civic, charitable and health services to patients and the community. He is the first recipient of this newly-created award. ***Dr. Paul Seebohm,*** *special counsel to the Dean and professor emeritus at the University of Iowa College of Medicine, was awarded the Distinguished Service Award and* ***Dr. Jackson Ver Steeg,*** *Des Moines anesthesiologist and IMPAC chairman, received the Merit Award.*

Awards, appointments, etc.

Carroll Medical Center and Physicians Clinic of West Central Iowa, the largest medical practices in Carroll, have formed a corporation to merge the two offices. Beginning January 1995, the two practices will become Medical Associates of Carroll, P.C. **Dr. James Jensen** and **Dr. James McQueen** have been elected president and vice president. Other physicians involved in the merger include **Dr. John Carroll, Dr. Jeffrey Larkin, Dr. Dominador Garcia** and **Dr. David McCoy,** all of the Carroll Medical Center. The Physicians Clinic staff includes **Dr. Brent Liebert, Dr. Francis McCabe** and **Dr. Richard Peters. Dr. Robert Christensen** and **Dr. Charles Fangman** will be joining the new corporation. The primary specialties of these physicians are family practice, internal medicine and general surgery. **Dr. Antonio Damasio,** professor and head of the Department of Neurology, UI College of Medicine, has been elected to membership in the European Academy of Sciences and Arts. The Academy, which brings together scholars in physical sciences, biological sciences and the humanities, includes 27 members from the U.S. **Dr. Roy Overton, II,** Des Moines, has been appointed to the Covernor's Committee of Geriatric Abuse. **Dr. Julianne Thomas,** Cedar Rapids pediatrician and **Dr. Stephen Gleason,** Des Moines family practitioner, celebrated Iowa Day, February 25 at the White House. Topics discussed included health system reform and welfare reform. The Iowa-Stavropol medical exchange program recently sent an Iowa delegation to the Russian city. Physicians who made the two-week trip included **Dr. Peter Stephens,** Cedar Rapids pathologist, **Dr. Jose Angel,** Des Moines internist and **Dr. Laverne Wintermeyer,** Des Moines pediatrician and medical advisor to the Iowa Department of Public Health. **Dr. Rhea Allen** has joined the family practice department at Muscatine Health Center, P.C. **Dr. Myra Daniel** has joined Bettendorf Family Medical Center. Dr. Daniel specializes in family medicine and obstetrics. Dr. Cory Dietz, family practitioner, has joined Mount Vernon Medical Associates.

Life members honored at Annual Banquet

Life membership is accorded to those physicians who have practiced for 50 years and have been an IMS member for the last 15 consecutive years. The following physicians fit that criteria and were named life members at Saturday evening's Annual Banquet, April 16:

Charles Beckman, MD, Kalona
Edmund Burke, MD, Adel
Loran Coppoc, MD, Iowa City
David Culp, MD, Iowa City
Mary Dewey, MD, Iowa City
Paul Ekart, MD, Ottumwa
Roland Erikson, MD, Davenport
John Hennessey, MD, Manilla
Hal Hirleman, MD, Cedar Rapids
Robert Hoffmann, MD, Des Moines
Van Hunt, MD, Mason City
Newell Ingle, MD, Cedar Rapids
John MacGregor, MD, Mason City
John McCoy, MD, Cedar Falls
John Moberly, MD, Dubuque
Ranald Olson, MD, Muscatine
Robert Pfaff, MD, Dubuque
Richard Paul, MD, Des Moines
Christian Schrock, MD, Iowa City
Ian Smith, MD, Iowa City
Jack Spevak, MD, Des Moines
Robert Storck, MD, Dubuque
John Tiedeman, MD, Sioux City
John Westly, MD, Mason City
James Widmer, MD, Wayland
James Young, MD, Clinton

Deceased member

Carl Hanson, MD, 79, life member, Tucson, Arizona, died February 3

New members (as of January 1994)

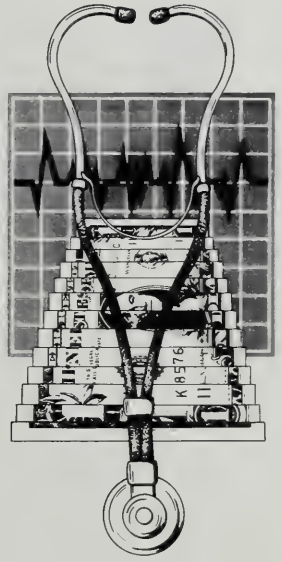
Mason City
K. George Woodward, MD, psychiatry
Oskaloosa
Kymberly Life, DO, internal medicine
Ottumwa
Daniel Rothfuss, MD, radiation/oncology
Shenandoah
Dean Teeter, DO, general practice
Sioux City
Jeffrey Kellogg, DO, family practice
Seung Kim, MD, family practice
Francis Lee, MD, general surgery
Thomas Manning, MD, radiology
Jolene Meis, MD, pediatrics
Kevin Murray, MD, cardiovascular surgery
Radha Rao, MD, oncology/hematology
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The Information Highway — WHERE WILL IT TAKE PHYSICIANS?



While the Iowa Legislature struggles with political issues such as who will own the state's fiber optics network and who will be allowed into it, physicians are envisioning its possible uses in health care. Some say telemedicine could revolutionize the practice of medicine, especially in rural Iowa.

During the 1994 Iowa Legislature, the Iowa Medical Society worked to convince lawmakers that physicians should have access to the state's fiber optic network. Meanwhile, physicians are only beginning to imagine how fiber optics could change medical practice.

"It's an exciting time for medicine," comments Dr. Laine Dvorak, a Humboldt family physician who is one of four IMS members appointed by Governor Branstad to the Iowa Telemedicine Advisory Council. "We've only begun to identify applications of fiber optics."

The Iowa Communications Network (ICN) is actually several thousand miles of fiber optic cable — a kind of high tech umbilical cord connecting about 100 points throughout the state. The Iowa Legislature approved construction of what some call the 'super information highway' because of its potential for enhancing rural education. However, the ICN is now touted as the beginning of a telecommunications revolution with nearly unimaginable potential.

Though the Telemedicine Advisory Council is charged with establishing a plan for telemedicine, the Iowa Legislature — with the exception of three "teaching hospitals" — has yet to allow physicians and hospitals onto the network.

"Giving the medical profession access to fiber optics is simple common sense," says Dr. Kevin Cunningham, a Des Moines internist who is chairman of the IMS Legislative Committee and a member of the Telemedicine Advisory Council. "However, politics are bound to enter into the issues of how the system is accessed, particularly as it affects rural primary care and urban specialty care."

System 'a natural' for CME

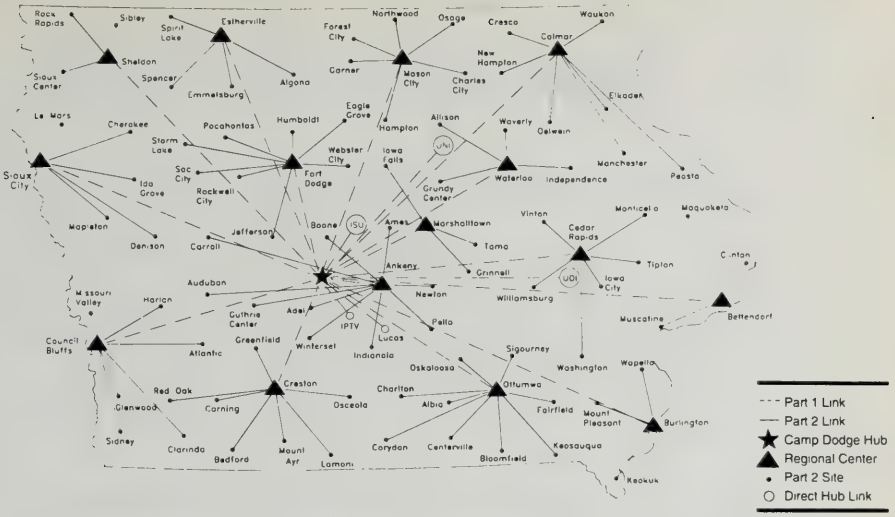
No one knows who will gain final control of the potentially lucrative telemedicine market, but Iowa physicians on the Telemedicine Advisory Council are excited about the system's potential, no matter who ends up owning it.

The ICN was designed as an education network and will be "a natural for continuing medical education" says Dr. Michael Kienzle, interim associate vice president for clinical affairs at the University of Iowa.

"CME will probably be the easiest and earliest fiber optics application in medicine," comments Dr. Kienzle, another member of the Telemedicine Advisory Coun-

Giving the medical profession access to fiber optics is simple common sense.

Christine Clark
Ms. Clark is director of communications for the Iowa Medical Society and managing editor of Iowa Medicine.



The Iowa Communications Network originates from a central control facility at the Camp Dodge National Guard Base near Des Moines. Part I includes 15 regional centers, three regent universities and links to Iowa Public Television and the State Capitol. Part 2 is 84 separate fiber optic links from the 15 regional centers to each of the remaining counties.

cil. Dr. Kienzle and Becky Roorda, IMS manager of public affairs, are ex-officio members of an Iowa Hospital Association telemedicine task force. "We have plenty of CME programs available. This will provide a way to deliver them."

Put travel money into equipment

The high quality two-way audio/visual communication available through the ICN will make broad-based continuing education available to all medical professionals, Dr. Kienzle explains.

"For example, continuing education for nurses and other providers has often been problematic because of the expense involved in time away from the hospital. If money used for travel could be put into equipment, continuing education could be provided right in the hospital," he adds. "I believe hospitals will soon be scrambling to construct in-house classrooms."

"The educational potential of ICN is clear," agrees Dr. Dvorak. "It can be a way for the University to reach out, but also a way for practicing physicians to present cases to medical students in Iowa City. These will be good advances for medicine."

Atlantic family physician Dr. Elaine Berry, another Council member, agrees the ICN has great potential in CME. However, she also sees potential pitfalls.

"I'm not sure if all CME should be offered through the local hospital, especially in rural areas. I might have trouble focusing on CME topics if I'm in the hospital and my beeper is going off."

Another early application of fiber optics could be information support for physicians.

"Any physician will be able to use the ICN to access a wealth of medical literature through advanced electronic medical library services. This would give them the ability to do literature searches on particular topics or find specific articles," Dr. Kienzle explains.

Perhaps even more exciting is the U of I's "Virtual Hospital Project" which could eventually be available to physicians on the ICN.

"Physicians could select electronic textbooks, digitized lectures and patient instruction. ICN would provide a smorgasbord of information now available only through technology that is too expensive for widespread use."

If money used for travel could be put into equipment, continuing education could be provided in the hospital.

Far-reaching clinical applications

CME and information access for physicians are important, but it is the clinical applications of fiber optics which have the greatest potential to change delivery of health care.

"The image quality of ICN teleradiology is much better than anything in existence. I suspect this will be one of the first clinical applications widely used in Iowa," relates Dr. Kienzle.

"The cost of sending images has been prohibitive, even for our hospital," concurs Dr. Berry. "Obviously, lower-cost fiber optics can really help us in this area."

Image transmission over ICN will not be limited to X-rays. Physicians are discussing a variety of possible uses in pathology, cardiology and dermatology.

continued next page

continued



"The quality of the images is so good that a dermatologist could examine a skin lesion using the ICN," Dr. Kienzle explains.

Physicians are also considering the implications of face-to-face consultation services between primary care physicians and specialists hundreds of miles away which could take place in the local hospital.

"There are some access-related medical disadvantages to living in rural areas and ICN could help overcome them," comments Dr. Cunningham.

Also significant will be the wealth of patient data which could be available through ICN. This could include medical records and patient reports from any previous hospitalization.

In a recent report, the AMA Council on Medical Service said telemedicine's ability to improve record keeping and store patient encounters on videotape could even decrease physician exposure to malpractice suits.

However, Lori Atkinson, risk management coordinator for Midwest Medical Insurance Company, says it is way too early to speculate.

"There could be an up side — increased access to consultants for rural primary care physicians. But the down side could be a decrease in hands-on diagnostic access to patients by specialists."

It may not be for everyone

Any new technology raises a plethora of questions and telemedicine is no exception. Many questions will not be answered until the technology is in use. Physicians are quick to point out that cost is a key unknown factor.

"People are assuming there will be cost savings, but many applications haven't really been tested," comments Dr. Kienzle. "With technology, enthusiasm sometimes outstrips reality."

Dr. Dvorak believes the equipment costs will decrease with time, but not enough so every physician will be on line with the ICN.

"I don't see this technology in every office, but I do see it in every hospital."

Dr. Berry confesses she feels "a little tenuous" about claims that ICN will be a technological miracle.

"It's difficult for two physicians to get together, no matter what technology is involved. I don't think it can totally replace talking shop with colleagues and I believe some consults will still have to be done in person."

While she agrees with IMS efforts to get physicians into the ICN, Dr. Berry urges caution. "I don't want this to be a toy we all put money into and then find out it isn't as useful as we thought."

Dr. Cunningham agrees the question of who should have the technology must be addressed, but says his priority is keeping the door open for physicians.

"If we don't maintain access, choices for rural physicians could be severely restricted," he cautions.

Remember the businesses that bought computers and didn't train their employees?

Finally, Dr. Kienzle emphasizes the importance of training.

"Remember the businesses that bought computers but didn't train their employees? Some physicians are still afraid to turn on a computer and training could be a key factor in the success of telemedicine. This thing has to be carefully planned." IM

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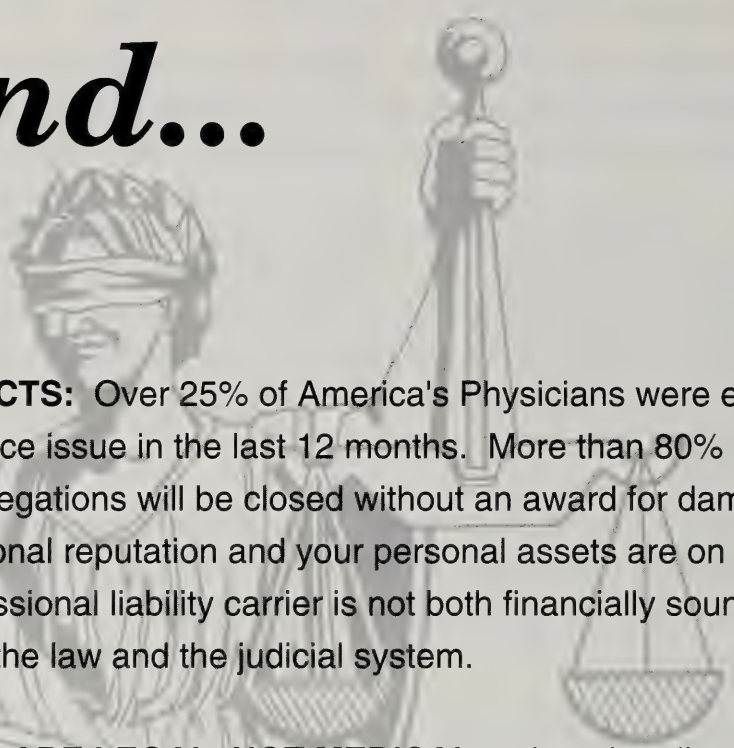
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Laboratory evaluation of antiphospholipid syndromes

● HARRISON PRATT, DO

The role of immunologic factors as a cause of disordered blood coagulation became evident in 1952 with the discovery that 10% of patients with systemic lupus erythematosus (SLE) had a factor in their blood that caused prolongation of the partial thromboplastin time with seemingly paradoxical tendencies to thrombosis. Subsequent studies showed the "lupus anticoagulant" to be an antibody (IgG or IgM, or both) reacting against epitopes on prothrombinase (a complex of Factor Xa, Factor Va, phospholipid, and calcium).

Although the lupus anticoagulant is an antibody, its presence is defined on the basis of its behavior in tests of blood coagulation. The lupus anticoagulant has been detected more recently in over half of patients with SLE using a sensitive modified PTT.

Anticardiolipin antibodies cause clinical effects and laboratory findings similar to those produced by the lupus anticoagulant. These antibodies (IgG, IgA, or IgM) also are found in the plasma of most patients with the lupus anticoagulant, but either type of antiphospholipid antibody may occur independently of the other. Unlike the lupus anticoagulant, anticardiolipin antibodies typically are measured by immunoassay, similar to measurements of other antibodies

The association of antiphospholipid mediated coagulopathy with clinical thrombosis is called the antiphospholipid-thrombosis (APL-T) syndrome. The APL-T syndrome may occur in otherwise normal individuals (*primary APL-T syndrome*) as well as in patients having SLE or other diseases (*secondary APL-T syndrome*). Patients with primary antiphospholipid syndrome usually have either lupus anticoagulant or anticardiolipin antibody, but those with underlying disease commonly have both lupus anticoagulant and anticardiolipin antibody. The tendency towards arterial and venous thrombosis increases with rising antibody titers, with about a 33% incidence of thrombosis in patients with lupus anticoagulant. The clinical features of the APL-T syndromes are summarized in Table 1.

Other important manifestations of the syndrome include recurrent fetal loss and thrombocytopenia. Up to 30% of patients with either type of antibody may have low titer false-positive serologic tests for syphilis. Four distinct types of APL-T syndrome have been identified, separated into Type I through Type IV syndromes on the basis of the clinical pattern of thrombosis. Although this subclassification is important as an indicator of appropriate anticoagulation, there is no correlation with the type of antiphospholipid antibody or antibody titer.

The most common presentation of APL-T is an unexplained, usually mild, prolongation of a partial thromboplastin time (PTT), or less often, prolongation of the prothrombin time (PT). Marked prolongation of *in vitro* clotting tests is uncommon, but does occur. The second manner of presentation is arterial or venous thrombosis occurring in a clinical setting that is not normally associated with a hypercoagulable state. This may take the form of venous thrombosis and pulmonary embolism or arterial thrombosis in an unexpectedly young person without serious illness.

A third mode of presentation occurs in gestation: recurrent spontaneous abortion in the first trimester, recurrent fetal wastage in the second and third trimesters, placental vasculitis and maternal thrombocytopenia. A syndrome of postpartum fever, pleuritic chest

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for May 1994.

HARRISON PRATT, DO
Dr. Pratt is a pathologist practicing at Mercy Hospital Medical Center in Des Moines.

Laboratory evaluation of antiphospholipid syndromes

continued

TABLE 1
OVERVIEW OF ANTIPHOSPHOLIPID-THROMBOSIS SYNDROMES

	Anticardiolipin thrombosis syndrome	*Lupus anticoagulant thrombosis syndrome*
Relative prevalence	5 to 6 times more common than lupus anticoagulant syndrome (when occurring as a primary APL-T syndrome)	Less common than anticardiolipin syndrome (when occurring as primary APL-T syndrome)
Common clinical features	Arterial and venous thrombosis Pulmonary embolism Recurrent fetal loss Thrombocytopenia Anticardiolipin antibody and lupus antigoagulant may occur simultaneously in the secondary APL-T Syndromes	
Differences in prevalence	Both arterial and venous thrombosis occur, frequently in the same patient Associated with premature coronary, cerebrovascular, and retinal vascular disease	Predominantly venous thrombosis, less common arterial thrombosis
Associated conditions	SLE and other connective tissue disorders Malignancy HIV infection Drug therapy Various other medical conditions	
Principals of laboratory diagnosis	Demonstrate presence of IgG, IgA, or IgM antibodies against cardiolipin by Enzyme -linked immunosorbent assay (ELISA)	Demonstrate coagulation abnormality using dilute Russell's Viper Venom Test (dRVVT) Abnormality is correctable by addition of phospholipid to the assay mixture
Cautions	Unmodified PTT alone is unreliable for detection of antiphospholipid antibodies in patients with clinical thrombosis Antiphospholipid antibodies may "mimic multi-factor deficiency" pattern with clotting factor assays Measures of antiphospholipid level correlate poorly with tendency to thrombose	

pain with dyspnea, pleural effusion, pulmonary infiltrates, and cardiomyopathy with ventricular arrhythmias may occur up to 10 days post partum in association with antiphospholipid antibodies.

Evaluation of patients suspected of having the APL-T syndrome is complicated by the need to test for 2 different classes of antibody using both immunologic and coagulation tests for the antiphospholipid antibodies. Evaluation is further complicated by the differing modes of clinical presentation of the syndrome, by the common sources of variance in in vitro tests of blood coagulation, and by conflicting claims of analytical superiority by competing manufacturers of laboratory reagents.

Investigation of the APL-T syndrome requires both immunologic tests for anticardiolipin antibodies and coagulation tests for abnormalities correctable by addition of specific phospholipids. Patients with the secondary APL-T syndrome commonly have both anticardiolipin antibodies and the lupus anticoagulant, whereas most individuals with primary APL-T syndrome have only cardiolipin antibody. Fewer than 1 of 5 with the primary syndrome have only the lupus anticoagulant.

Asymptomatic individuals suspected of having either anticardiolipin antibody or the lupus anticoagulant need appropriate laboratory evaluation. The presence of either factor significantly increases the risk of thrombosis in response to even minor thrombotic challenge. Diagnosis of the syndrome should lead to prophylactic anticoagulation of these otherwise normal individuals when they are in conditions predisposing to thrombosis. Routine prophylactic anticoagulation is not indi-

TABLE 2
TESTS FOR EVALUATION OF PRIMARY HYPERCOAGULABLE STATES

Abnormality	*Test*	*Comment*
Anticardiolipin antibody	Anticardiolipin IgA, IgG, & IgM by solid phase ELISA	Not altered by anticoagulant therapy Titers may transiently decline to normal during an acute thrombotic episode
Antithrombin III (AT-III) deficiency	AT-III (functional assay), followed by immunologic assay if functional assay is decreased	Increased by anticoagulation Functional assay is preferred as a screening test Failure to respond adequately to heparin therapy may indicate AT-III deficiency
Lupus anticoagulant	dRVVT with phospholipid neutralization if initial results are abnormal	Results altered by heparin therapy; heparinase pretreatment of the blood sample may obviate interference Titers may transiently decline to normal during an acute thrombotic episode
	Kaolin Clotting Time (KCT)	KCT is reported to vary in proportion to severity of thrombotic tendencies in APL-T syndromes
Protein C deficiency	Protein C assay (functional assay), followed by immunologic assay if functional activity is decreased	Decreased by coumarin anticoagulants; wait 2 weeks before testing Can compare results with Factor II assay to assess effect of coumarin Normally there is a proportionate decrease of Factor II and Protein C
Protein S deficiency	Protein S assay (functional assay), followed by immunologic assay if functional activity is decreased	Decreased by coumarin anticoagulants; wait 2 weeks before testing
Homocystinuria* (cystathionine β-Synthetase deficiency	Plasma homocysteine level; may require *methionine loading test* for diagnosis in heterozygotes	Increased results also occur in Vitamin B12 and Vitamin B6 deficiency, methotrexate or anticonvulsant therapy, renal or hepatic failure, and in menopause.

** Although homocysteine is not a clotting factor, increased levels are associated with accelerated blood vessel injury, resulting in premature myocardial infarction and stroke. A clinical hypercoagulable state may exist due to vascular changes.*

cated for asymptomatic individuals without a history of thrombosis. However, it may be advisable to anticoagulate such individuals if they undergo major surgery, prolonged immobilization or take drugs known to accelerate blood coagulation such as oral contraceptives.

Prolongation of a coagulation test

Blood coagulation tests must be evaluated in the context of the patient's clinical state and with appreciation for the many factors that artefactually or physiologically prolong the PTT and PT. The tests listed in Table 1 cost approximately $100 each, except for homocysteine, which costs approximately $160. Because of the high cost of indiscriminate testing in this setting, the following questions should be answered before initiating laboratory testing:

● *Is the prothrombin time abnormal?* APL-T syndrome usually presents as isolated mild prolongation of the PTT. Abnormality of the prothrombin time should prompt consideration of other factors causing abnormal coagulation tests, although the PT may be prolonged by anti-phospholipid antibodies. Acute hepatic congestion and antibiotic therapy are 2 occasionally unrecognized causes of unexplained prolongation of prothrombin time.

● *Has this patient received heparin in the last 24 hours?* All heparin administered to hospitalized patients is not given as the result of a physician's order. A "heparin flush" of an intravenous line can cause an otherwise inexplicable prolongation of PTT that triggers an expensive, unwarranted laboratory investigation.

● *Is the* in vitro *abnormality reproducible?* Inadequate mixing of blood sample after phlebotomy, minor contamination of the sample with tissue thromboplastin during a difficult phlebotomy and collection of samples through indwelling vascular catheters are common causes of abnormalities of PTT and prothrombin time. Prolongation of PTT in the APL-T syndromes is usually repro-

Laboratory evaluation of antiphospholipid syndromes

continued

ducible, although the clotting times may vary in some patients.

The testing strategy for this clinical presentation should be to obtain results of Anticardiolipin Antibody (IgG, IgA, and IgM) tests and dilute Russell Viper Venom Test (dRVVT) followed by phospholipid neutralization in the dRVVT if the initial screen is abnormal. The finding of either anticardiolipin antibody or a prolonged dRVVT correctable by addition of phospholipid is evidence of antiphospholipid antibody.

Rare causes of hypercoagulable states include fibrinolytic abnormalities such as hypoplasminogenemia, dysplasminogenemia, tissue plasminogen activator release deficiency, and increased levels of plasminogen activator. Other rare causes include dysfibrinogenemia and heparin cofactor deficiency. Diagnosis of these conditions requires referral to or close interaction with a center specializing in coagulopathies.

Thrombosis inappropriate for the clinical setting

Arterial or venous thrombosis in someone who is clinically well or in an innocuous clinical setting should be followed by testing for the common hypercoagulable states, especially if the patient is young. Although an antiphospholipid antibody is the most common cause, abnormalities of the coagulation system or amino acid metabolism may also produce thrombosis and vascular occlusion.

Most of the tests listed in Table 2 are significantly altered in response to disease or anticoagulant therapy. It may be difficult to determine whether low levels of a natural inhibitor of coagulation are due to consumption, due to hereditary deficiency, or due to failure of the organ synthesizing the protein.

Repeat testing when the patient's clinical condition has improved, preferably on an outpatient basis, is usually required to demonstrate a persistent abnormality of blood coagulation that might indicate a hereditary abnormality of blood coagulation.

About 1 patient of 14 with deep venous thrombosis has an identifiable hereditary coagulation inhibitor deficiency. If a potentially heritable inhibitor deficiency is identified in a patient, a family history with testing of family members for inhibitor deficiency is indicated.

Since not all patients with the APL-T syndrome have prolongation of PTT or PT, it is important to include testing for antiphospholipid antibodies when testing of patients with suspected hypercoagulable disorder.

Appropriate initial testing includes screening for APL-T syndrome plus measurement of AT-III, Protein C and Protein S. The presence of unusually advanced vascular disease for the patient's age may make evaluation of plasma homocysteine level an appropriate test. IM

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Are your patients taking a big hit?

On the subject of whether physicians should accept credit cards in payment of their professional fees, the Iowa Medical Society and the American Medical Association maintain a neutral stance.

According to a recent news release from VISA, in 1993 more than 40% of all physician's offices nationwide accepted VISA cards. This represents a 17% increase since 1992. The acceptance of other credit cards may increase these figures. In contrast, VISA cards are now accepted by 90% of all hospitals and 70% of all dental practices nationwide.

Credit cards are easily — some might say too easily — obtained. Many are initially granted without formal application. Too many people have gone "wild" with easily-obtained credit and have over-extended themselves. This leads to bankruptcy, the need to seek financial advice, or dependence on "old Dad" to bail them out. (Yes, I have had to bail out an offspring, as I'm sure, have many of my readers.)

A recent article in the *Sunday Des Moines Register* (February 27, 1994, page G1-2) affirms that financial illiteracy is reaching crisis proportions. There is no question that the acceptance of credit cards by the health professions will increase cash flow. The service charge is not great; there is a savings in billing and collection costs. With so many deductibles and co-payment insurance plans the credit card becomes an easy solution.

But, then the big hit comes . . . high interest rates, in some instances up to 18%. It is no wonder that VISA and other credit card firms are attempting to broaden their market into the health care fields. VISA card payment volume in the U.S. health care market grew by 18% to $4 billion in 1993. "VISA's corporate strategy of increasing volume in under-penetrated and new markets such as health care is helping fuel the overall growth of the VISA program in the U.S.", reads the VISA news release. That is a laudable objective and I am not opposed to the use of credit cards. However, I see a real need for controls. Too many people are over-extending themselves and become burdened by interest rates which are not obvious until the monthly statement is received. That little plastic card which is so easily obtained becomes a snare to the financially illiterate.

Do not be quick to help your patients get caught in the credit card snare.

My plea to my physician colleagues is this: do not be too quick to help your patients get caught in the credit card snare. We are trained to be compassionate with our patients regarding their health problems. Let us also be compassionate about their financial problems. Time payments without interest will not cause you undue loss of cash flow.

For those with large bills instruct your business manager to discuss various alternatives to the one in need. You'll feel better for knowing that you are not helping trap a young couple with large credit card balances and no foreseeable relief. IM



Marion Alberts, MD

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Where do we learn to care?

Often I read want ads, partly because they're interesting "windows-on-the-world" and partly because I'm intrigued by the techniques employed. A recent ad in the *JAMA* locum tenens section caught my eye, but not because I'm seeking a spot, thank you. Its bold letters at the top declared: "We're looking for physicians who didn't learn everything they know in medical school."

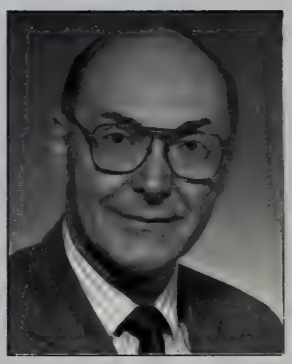
A strong fan of continuing education, I smiled somewhere in my cerebral cortex, leading me to read what followed in smaller type: "There are certain things you can't learn in school. Like caring and concern for patients."

Now that cerebral smile changed into a hypothalamic storm. I felt my blood pressure rise as a surge of adrenalin squirted out to all my languishing receptors, a response to the idea that physicians not only don't learn caring and concern for patients in school, but that they can't. What an outrageous claim! (See, I'm still boiling; you can tell by the exclamation point.)

I remember various teachers from kindergarten through graduate school who were excellent role models for caring and concern. It probably wasn't listed in their course objectives, but I remember yet many acts of kindness and compassion. I remember such behavior in many of my medical school and residency teachers. Two objections arise at once: (1) Those teachers may have exhibited such behavior, but if I indeed learned it, did I learn it from them rather than from parents, relatives, neighbors, friends or even radio programs like Jack Armstrong, All-American Boy? (2) Maybe those old-timers were good teachers and role models, but the new breed isn't like that. Baloney. In recent years, as a referring physician and as a patient, I've encountered many acts that add up to compassion. What's the source of all that? The curriculum planners for medical schools realize how important those behaviors are and that they are achieved not mainly through lectures or reading assignments, but through role-modeling. Although tough to write into a lesson plan, such behaviors can be learned. (Arriving at medical school with an ample supply of the milk of human kindness helps, I admit.)

It probably wasn't listed in their course objectives, but I remember many acts of kindness.

I believe the instruction works, but to be fair, I suppose it has both complete and partial failures. And perhaps the number of those has increased over the past 20 to 50 years. So it's worthwhile for our current effort in curriculum review to try hard to address this problem. If we take the long view, such as the Hippocratic oath or the ethical stance of most religions, the problems have been with us for a long time. For the short view, we can point to the general nastiness found in modern life and realize that education can't overcome all that. I hope you're as convinced as I that caring and concern can be learned in school, but also in many other places, one of which is the classroom of life where our colleagues and our patients are our teachers. IM



Richard Caplan, MD

Classified Advertising

Emergency Medicine
Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Marshalltown, Iowa—Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Numerous other Iowa locales. ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

Immediate Opening—One internist or family practitioner (internist preferred) at a 200-bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. Forty hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $74,640.00. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644. Telephone: 319/334-2583. An Equal Opportunity/Affirmative Action Employer.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Director, Internal Medicine Residency Program—Internal medicine residency program in Des Moines, Iowa seeks an experienced board certified physician director with academic and clinical experience. Program is affiliated with the University of Iowa Hospitals and Clinics and currently has 23 residents. Attractive salary and benefits. Send CV to Medical Education Services Office, Iowa Methodist Medical Center, 1200 Pleasant Street, E-508, Des Moines, Iowa 50309.

Cedar Rapids, Iowa—Established all emergency medicine boarded group seeking BC/BP emergency physician to join 6-member group. Brand new ED, highly trained staff, approximately 35,000 ED census. Will be double coverage with 8-hour shifts. Competitive compensation package. Contact: 319/398-6047 or send CV to Mercy Trauma Physicians P.C., 701 10th SE, Cedar Rapids, Iowa 52403-1251.

Family Practice, Carroll, Iowa—Outstanding professional opportunities for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197, or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Explore Minnesota and Primary Care—With North Memorial Medical Center primary care network. Openings are available for: family practice, internal medicine and OB/GYN physicians and physician assistants. These opportunities offer stability without sacrificing autonomy. Single and multispecialty groups in urban, suburban and semi-rural settings. Teaching opportunities with North/University of Minnesota residency program. Competitive compensation structures and flexible schedules with independent or hospital owned group practices. Immediate access to Minneapolis/St Paul attractions. Central to Minnesota's abundant lakes country. If you are BC/BE send your CV or call in confidence to North Medical Programs, North Memorial Medical Center, 3300 Oakdale Avenue North, Robbinsdale, Minnesota 55422-2900. Nationwide and Canada 1-800/275-4790.

Internal Medicine, Family Practice and OB/GYN Practice Opportunities—Rural lake country community is seeking the above practitioners to join an active 12-physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquires to Lake Region Clinic, PC, Attn: Joel Rotvold, P.O. Box 1100, Devils Lake, North Dakota 58301 or call collect at 701/662-2157 for further information.

Emergency Medicine/Locum Tenens

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Emergency Medicine Spencer, Iowa

Immediate opportunity for primary care trained or experienced emergency physician. Spencer Municipal Hospital is a progressive 131-bed hospital with a staff of 30 physicians representing major specialties. 8400 volume/24-hour shifts. Spencer is a community where country charm and modern lifestyles go hand in hand. Vacation year round on the Iowa Great Lakes of Lake Okoboji and Spirit Lake. Spencer also has a variety of restaurants and shops, much more than typically found in a community of 12,000. Highly rated award winning schools make Spencer an excellent place to raise a family. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Opportunities Available—Family practice, emergency medicine, internal medicine, locums, ob/gyn, occupational medicine, pediatrics, urgent care opportunities available in Minneapolis/St. Paul and leading communities within a 150 mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, Minnesota 55430; 1-800/248-4921 or 612/574-7627.

Family Practice Physicians—Gundersen Clinic is a 300-member multispecialty group practice which is adjacent to Lutheran Hospital, La Crosse, Wisconsin, a 402-bed tertiary care facility. As a result of our continued growth and a 100-year tradition of exceptional medical care, we are seeking family practice physicians with interest in routine obstetrics. Currently, we are recruiting family practice physicians to serve in our main La Crosse clinic, plus each of these branch clinics: 1) Gundersen Clinic, Decorah, Iowa; 2) Gundersen-Farrell Clinic, Prairie du Chien, Wisconsin; and 3) Gundersen-Mubarak Clinic, Tomah, Wisconsin. Our clinics provide specialized and primary care to nearly 70,000 families through over 745,000 visits per year. Our family practice group is the second largest department in the Gundersen system. Call groups vary in size depending on the community. The successful candidates will enjoy full administrative and technical support while being allowed to exercise your medical judgement without intervention. You will be encouraged to develop your practice based upon the needs of the community. In addition, we also offer extensive opportunities for continued education, and to perform clinical research. For more information, including salary and benefits, send your CV or call Tim Skinner toll-free 800/362-9567 or call collect 608/782-7300, ext. 6673. Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601. An equal opportunity employer.

Emergency Medicine, Council Bluffs, Iowa—Opening available for qualified physician to join group of emergency physicians. Training and/or certification in primary care specialty or emergency medicine. Flexible scheduling. Newly remodeled emergency department. Enjoy a rural and urban atmosphere. Write Bluffs Emergency Care Services, P.C., 933 East Pierce Street, Council Bluffs, Iowa 51503; 712/328-6111.

Family Practice, Minnesota—BC/BE family practitioner to expand current 23-member department. Enjoy a lifestyle of call every 21-23 days and an average 4-day work week. Just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of our physician-owned and directed group earn a highly competitive income and excellent benefits including paid vacation and CME, pension plan, all insurances paid and partnership potential after one year. Please respond with CV to John Bordwell, MD, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-7035.

Primary care physicians needed—Community Health Care in Davenport, Iowa, is overwhelmed by demand and needs to add physicians to its current staff. In addition, expansion is on the horizon. We are searching for pediatricians, family practitioners and obstetricians. The group already includes those specialties plus an internist, several mid-level providers as well as a dental department. On-site facilities include lab, pharmacy and x-ray. The 2 local 250-bed hospitals are merging. Davenport isn't flooded any more; great schools and good recreational opportunities. Competitive salary/benefit package. Contact Rebecca Wiese, MD, Medical Director, 428 Western Avenue, Davenport, Iowa 52801; 319/322-7899, fax 319/322-4013.

General Medicine—An opportunity to practice in a state hospital that offers: adult and geropsychiatric programs, realistic caseloads and 40-hour week, limited O.D. call, weekends free, generous employee benefit package, recent renovation of patient living unit, excellent community support and housing on campus. Salary ranges are from $91,250 for physician specialists to $111,087 annually for board certified psychiatrists. Contact Mark Lund, Supt., Clarinda Treatment Complex, Box 338, Clarinda, Iowa 51632 or call at 712/542-2161. AA/EEO. Position available July 1994.

Emergency Medicine Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President at 507/389-8500 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Practice or Equipment for Sale—Because of disability of doctor...16 years patient base...equipped with the usual internal medicine/general practice equipment including EKGs, PFT, Holter/Treadmill, Ultrasound, Blood Pressure Monitor, etc. Write to IOWA MEDICINE, Box 100, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Equipment for Sale—IMEX Mascot D201, Vascular Doppler, 2 scopes, never been used. $795.00 brand new, asking $600. Contact Dr. Donald A. MacKenzie, 515/967-3996.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Emergency Medicine—McFarland Clinic, P.C., is actively recruiting a BE/BC family medicine physician. Physician will participate in rotation of 24-hour on-site emergency coverage at Mary Greeley Medical Center, a 200-bed hospital located in Ames, Iowa. Emergency Department, rated Level II JCAHO accredited, is staffed by family practice physicians where approximately 15,000 patients are seen annually. Patient mix is midwest suburban with a low incidence of major trauma and drug-related problems. As a multispecialty clinic of 96 physicians representing over 25 medical and surgical specialties, McFarland Clinic physicians provide 1st and 2nd medical back-up for ER physicians as well as specialty physicians on-call for needed consultations. McFarland Clinic, P.C. offers excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

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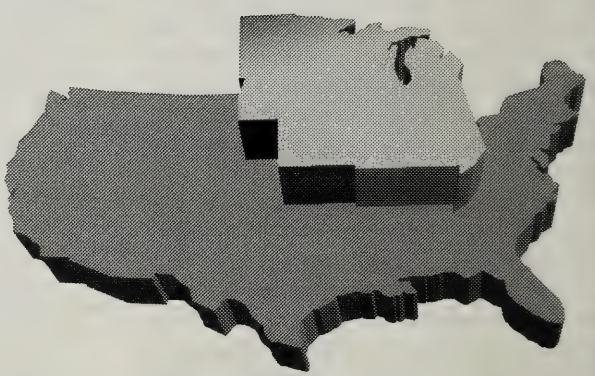


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Iowa physicians are focusing as never before on health care delivery. What will be the format? How should you be positioned to contend successfully with the impact of inevitable change?

As you seek to safeguard and enhance your professional future, remember you also need to assure the stability of the health care coverage you carry for yourself, your family and possibly your employees. With uncertain times ahead, you are wise to be protected by a strong insurance organization.

The Iowa Medical Society Statewide Physicians Health Program covers nearly 10,000 lives. It has been here for IMS member physicians, their families and employees through Blue Cross and Blue Shield of Iowa for more than 30 years.

The IMS program in 1994 is competitive, has numerous options and is coverage you can count on.

Please contact us at Bernie Lowe & Associates, Inc. We're the administrator/ broker for the Iowa Medical Society Statewide Physicians Health Program.

We can furnish complete information including rates for both traditional and managed care options. We will be happy to assist you in comparing the IMS program with your current coverage.

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515-222-0811 1-800-942-4718 FAX 515-222-0915
2700 Westown Parkway, Suite 410
West Des Moines, Iowa 50266-1411

Professional Listing

Allergy

John A. Caffrey, MD, PC
1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
1701 22nd Street, Suite 201
West Des Moines 50265
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
Asthma, Allergy & Immunology

Dermatology

Robert J. Barry, MD
1030 Fifth Avenue, SE
Cedar Rapids 52403
319/366-7541
Practice Limited to Disease, Cancer and Surgery of Skin

Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Electrodiagnosis

John Milner-Brage, MD
208 St. Francis Professional Building
Waterloo 50702
319/234-6446
Electromyography & Nerve Conduction Studies
Certified by American Board of Electrodiagnostic Medicine

Emergency Medicine

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
Comprehensive Emergency Medicine Practice, Locum Tenens, Doctor on Call

Emergency Practice Associates
P.O. Box 1260
Waterloo 50704
1-800/458-5003
Specialists in Emergency Staffing & Emergency Department Services

Family Practice

Acute Care, Inc.
P.O. Box 515
Ankeny 50021
515/964-2772 or 1-800/729-7813
Locum Tenens
Doctor on Call

Infectious Diseases

Chest, Infectious Diseases & Critical Care Associates, PC
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management

Internal Medicine

Fort Dodge Medical Center, PC
Cardiology
Samir G. Artoul, MD, FICC
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
Neurology, EEG, EMG, Evoked Potentia and Sleep Studies

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurosurgery

Iowa Medical Clinic Neurosurgery
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
Schoitz Medical Arts Center
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
1215 Pleasant, Suite 608
Des Moines 50309
515/283-5760
Neurological Surgery

Des Moines Neurosurgeons, PC
Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
2600 Grand Avenue, Suite 210
Des Moines 50312; 515/283-2217

Chad D. Abernathey, MD
1953 1st Avenue SE
Cedar Rapids 52402
319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
Earl R. Elowsky, MD
Timothy W. Neff, MD
600 Kenyon Road
Fort Dodge 50501
515/573-4141

Ophthalmology

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
540 E. Jefferson, Suite 201
Iowa City 52245
319/338-3623

North Iowa Eye Clinic, PC
Madison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Timothy F. Moran, Jr., MD
800 Pierce, Suite 106
Sioux City 51104
712/252-4333
General Ophthalmology

Fox Eye Institute
Lee Birchansky, MD
1953 1st Avenue, Cedar Rapids 52402
1400 7th Avenue, Marion 52302
1-800/I SEE YOU

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
309 East Church
Marshalltown 50158
515/754-6200

Satellite Offices
Lakeview Medical Park
6000 University Avenue, Suite 300
West Des Moines 50266
515/223-8685

804 South Kenyon Road, Suite 100
Fort Dodge 50501
515/576-7777

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

Otolaryngology

Iowa Head and Neck Associates, PC
Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
3901 Ingersoll
Des Moines 50312
515/274-9135

Dubuque Otolaryngology Service, PC
Thomas J. Benda, MD
James W. White, MD
Craig C. Herther, MD
310 North Grandview
Dubuque 52001
319/588-0506

Robert G. Smits, MD, PC
1040 5th Avenue
Des Moines 50314
515/244-8152
1-800/622-0002
Ear, Nose and Throat Surgery, Facial Plastic Surgery and Head and Neck Surgery

Iowa ENT, PC
Thomas A. Ericson, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
1-800/248-4443
1215 Pleasant, Suite 408
Des Moines 50309
515/241-5780

1200 35th Street, Suite 200
West Des Moines 50266
515/225-7761
Satellite Clinics:
Pella, Perry, Newton, Indianola, Oskaloosa, Guthrie Center, Lakeview Medical Park-West Des Moines

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
6000 University Avenue, Suite 310
West Des Moines 50266
515/224-9533

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-3105
Otolaryngology–Head and Neck Surgery, Facial Plastic Surgery, Allergy

Phillip A. Linquist, DO, PC
1000 Illinois
Des Moines 50314
515/244-5225
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

(Continued next page)

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Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Pain Management

Mercy Center for Pain Management
Randall L. Busch, MD, MS, DDS, Director
1890 John F. Kennedy Road
Dubuque 52002
319/556-7542
fax 319/556-8334

Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
600 7th Street SE
Cedar Rapids 52401
319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology

Des Moines Perinatal Center, PC
Neil T. Mandsager, MD
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
Maternal-Fetal Medicine
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High-Risk Obstetrical Management
High-Risk Deliveries

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Rehabilitation Medicine Associates
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Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Younkers Rehabilitation Center
Iowa Methodist Medical Center
1200 Pleasant
Des Moines 50308
515/283-6434

Mercy's Regional Rehabilitation Center
Mercy Hospital
1401 West Central Park Avenue
Davenport 52804-1769
319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Pulmonary Medicine

Chest, Infectious Diseases & Critical Care Associates, PC
Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Ronald L. Rains, MD
Pulmonary Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hour 515/224-1777

Fort Dodge Medical Center, PC
Robert C. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Surgery

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
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Joshua D. Kimelman, DO
Kirk D. Green, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Wendell Downing, MD
1212 Pleasant Street, Suite 410
Des Moines 50309
515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC
Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Urology

Fort Dodge Medical Center, PC
Leland M. Coffman, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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Government doesn't know best

This is my first column as your IMS president and I'd like to begin with a discussion of the choices we have before us. Not the nuts and bolts of what our health care delivery system will look like in another 10 years, but the basic philosophy which will shape those details. I'd like to talk about the choice between a marketplace driven by free competition and a government-directed collective.

In a perfect world, every person would share their resources to help their neighbors. Centralized decisions would be made without favoritism for the good of all. Proposals for a single-payer health care system and key components of the Clinton Plan assume that this is the world we live in. Other groups, while just as concerned about the need for universal and portable coverage, also worry about what more government mandates will do to free competition and creation of new jobs. We should be just as worried about what loss of freedom and professional autonomy could do to medicine.

The premise of the Clinton Plan is that government knows best about everything.

The premise of the Clinton Plan and others is that government knows best about everything — even how many primary care physicians and how many specialists there should be.

In a health care delivery system controlled by a national health board or other form of bureaucracy, individualism fades away. Think about what governmental involvement has meant in medicine during the past two decades. Consider the unfair reimbursement to rural Iowa hospitals and physicians which occurs under the government-run Medicare program. Consider the mountains of paperwork created since the government began involving itself in the practice of medicine. This paperwork has been instrumental in driving up the cost of medical care.

Are you aware of how much individual freedom physicians have already lost because government bureaucrats think they know more about what's best for our patients? After you answer these questions, ask a final one. Do physicians and patients want to travel farther toward an even more oppressive bureaucracy? It is difficult to believe more centralization of health care will be good for patients.



James White, MD

Physicians want health system reform as much as anyone else, perhaps more. But, we won't accept reform that crushes personal freedom . . . the freedom of physicians to choose their own career paths and practice medicine that helps people. And we won't accept reform that subjugates the freedom of Americans to choose how and from whom they seek care.

No matter how we differ among ourselves on the details of health system reform, I know all physicians in America have one future goal which is not up for negotiation or compromise . . . to continue providing the best health care in the world to our patients. The governmental bureaucracy which understands or can assist us with this goal will never be created. IM

IMS Update

AT A GLANCE

Doctors are taking their own advice. According to a recent study in JAMA, *3.3% of physicians smoke, down from nearly 19% in the 1970s.*

During his recent Detroit trial on charges that he violated Michigan's law against assisted suicide, Dr. Jack Kevorkian expressed "contempt for organized medicine and the socially-criminal American Medical Association." Dr. Kevorkian was acquitted.

In a letter to the president of Singapore, the AMA said caning should be abolished because it is a cruel form of punishment. The letter also said physicians should not be required to be present because such participation "conflicts with international standards of medical ethics."

The AMA Annual House of Delegates will be held Sunday-Thursday, June 12-16 in Chicago. Watch future issues of Iowa Medicine *for news from the meeting.*

IMS elects physician officers

James White, MD, a Dubuque otolaryngologist, was installed as president of the Iowa Medical Society on Sunday, April 17. The installation ceremony concluded the Society's 3-day House of Delegates and Scientific Session at the Hotel Savery. Dr. White graduated from the University of Iowa College of medicine and has served the IMS in many capacities.

Other physicians elected to office are:

President-elect (1-year term) — Joseph Hall, MD, Des Moines

Vice-president (1-year term) — Siroos Shirazi, MD, Iowa City

Trustee (3-year term) — John Brinkman, MD, Mason City

Speaker, House of Delegates (1-year term) — Donald Kahle, MD, Dubuque

Vice Speaker, House of Delegates (1-year term) — Tom Throckmorton, MD, Spencer

AMA Delegates (2-year terms) — Clarence Denser, Jr., MD, Des Moines; Bruce Trimble, MD, Mason City; Donald Young, MD, Solon

AMA Alternate Delegate (2-year term) — Thomas Graham, MD, Iowa Falls

Councilor, District III — Eugene Kerns, MD, Davenport; **Councilor, District VII** — Steven Erickson, MD, Cedar Falls; **Councilor, District VIII** — Leo Milleman, MD, Ames; **Councilor, District XII** — John Fernandez, MD, Council Bluffs; **Councilor, District XV** — Kathryn Opheim, MD, Sioux City; **Special Election, Councilor, District X** — Michael Disbro, MD, Des Moines

Three IMS physicians win awards

Jackson Ver Steeg, MD, a Des Moines anesthesiologist, received the IMS Merit Award at the Society's annual banquet Saturday evening, April 16. Dr. Ver Steeg received the award for his dedicated service to the Society's Iowa Medical Political Action Committee. He has been IMPAC chairman for over 16 years.

Dr. Paul Seebohm of Iowa City received the Society's Distinguished Service award, which has been given only three times. Dr. Seebohm, a past IMS president, joined the University of Iowa College of Medicine faculty in 1949 and retired in 1993 after serving as associate dean since 1974.

Dr. Peter Wallace, an Iowa City pediatrician, received the Society's newly-established Physician Community Service Award in recognition of his civic activities.

Two IMS staff members — Don Neumann and Tina Preftakes — were recipients of the John F. Sanford Award, which honors lay individuals for outstanding contributions to the medical profession.

Jack McDermott, manager of Orthopedic Surgery Associates in Davenport, received the Iowa Medical Society's Outstanding Medical Office Administrator Award.

House actions on willing provider issue

All physicians should have the right to apply to any managed care entity and managed care organizations should be required to disclose the criteria used to select, retain or recruit physicians. These two policy statements were

Specialty Society Update

Nearly 300 clinic managers and 72 exhibitors attended the May IMGMA Spring Meeting.

The American College of Cardiology, Iowa Chapter, will meet July 30 with chapters from Illinois and Wisconsin. Sponsored by Marion-Merrell Dow, the meeting will be devoted to health system reform.

The Iowa Psychiatric Society Standards and Economics Committee met recently with the IMS Subcommittee on Psychiatric Care and officials from the Department of Human Services to discuss new Medicaid managed care plans.

The newly-formed Iowa Association of County Medical Examiners will hold an education/business meeting October 28 at the Best Western Starlite Village in Ames. The group now has 50 members.

Nearly 75 physicians from Iowa and Nebraska attended the Iowa Society of Anesthesiologists Annual Meeting in late April.

Focus on IMS Alliance

The Iowa Medical Society and its Alliance enjoy a unique relationship. It is one of joint concern and communication with one common goal: improve the quality of health care delivery in Iowa. It is a privilege to be a player in an organization with such commitment. I thank the IMS for its financial support and encouragement of our projects.

The IMS Alliance is no longer a "what's for lunch bunch", but an enthusiastic group of professional, hard-working physician spouses determined to ride the waves of change to a positive outcome. Why not encourage your spouse to become part of this new Alliance?

Contributed by Barbara Bell, IMSA president

approved by the IMS House of Delegates at its annual meeting April 16-17.

In addition, the House approved a policy statement calling for the IMS to oppose any legislation which would require managed care entities to admit any physician or limited health care practitioner solely because the physician or practitioner is willing to abide by the requirements of the entity.

Other policy statements adopted by the House include:

- That the IMS do everything possible to establish a statewide universal Medicare payment schedule.
- That the IMS do everything possible to ensure that total budget dollars stay within Iowa if the state is granted single Medicare payment locality status.
- That witnesses in medical liability cases have comparable education, training and occupational experience in the same field as the defendant.
- That the IMS support .05% blood alcohol level as illegal for driving and .02% blood alcohol as legal intoxication level for drivers under age 21.

Iowa represented on AMA study group

John Rhodes, Jr., MD, a Pocahontas family physician, will be the Iowa Medical Society representative on a consortium which will conduct a major two-year study of organized medicine's structure.

The consortium will have 250-300 members and will analyze functions, processes and structural relationships among physician organizations. All levels of organized medicine will be represented. IM

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Health System Reform

IMS seeks Iowa IPAs, POs, other managed care entities

The Iowa Medical Society is trying to identify all Independent Physician Associations (IPAs), Physician Organizations (POs) and other physician managed care entities across Iowa. The IMS hopes to compile a complete list of all entities created by physicians to deal with managed care and a list of the groups' officers. The goal of the project, which is being done at the direction of the IMS Board of Trustees, is to provide regular networking opportunities for these physicians.

If you know of or are involved with an IPA, a PO or other entity, contact Tim Gibson, IMS vice president of programs and policy, by phone at 515/223-1401 or 800/747-3070 or by fax at 515/223-8420.

AT A GLANCE

Efforts to reform the health care system have spawned a lobbying battle unparalleled in breadth and cost. According to an Associated Press survey, over $100 million will be spent this year on advertising, lobbying, telemarketing and polling by health care interests. The cost may ultimately reach several times that amount.

Eighty-three percent of Americans have health insurance, a five percentage-point decrease from 1991, says the AMA.

A study released by Multinational Business Services says over 100,000 new government personnel would be required to implement the 818 mandates contained in President Clinton's health reform proposal. Estimated salary costs would be $3.9 billion.

IMS physician on 'transition team'

Dr. William Eversmann, Jr., a Cedar Rapids hand surgeon, is one of four health care providers serving on the newly-appointed Iowa Health Reform Transition Team. According to a letter from Governor Branstad's office, the team will "continue the work of the Health Reform Council during this vital time of health care reform". The transition team held its first meeting in mid-May and the governor says the team will complete its work by October 30, 1995.

According to Dr. Eversmann, the team is comprised of people "who have an interest and a wide knowledge base who are looking forward to coordinating ongoing reform in Iowa." He believes a "restructuring of the system is possible within the checks and balances in place."

The team will implement health system reform within the present system rather than seeking legislation. The team's stated purpose is to coordinate implementation of reform, communicate Iowa's concerns to the federal government and receive input from Iowans.

The 15-member team also includes representatives of the Iowa Association of Business and Industry, the Department of Human Services, the AFL-CIO, the Iowa Hospital Association, the University of Iowa and state agencies.

New AMA approach to universal coverage

The AMA Board of Trustees has approved what it calls "a new approach" to achieving universal coverage for and access to health services. The new policy has four components:

1) An employer mandate for firms with 100 or more employees; 2) An individual mandate with affordable sliding-scale subsidies for individuals in firms with fewer than 100 employees; 3) A health IRA as a mechanism to complement the employer/individual mandate; 4) A phase-in mechanism established at the time reform legislation is enacted.

Won't be BTUed again

According to the Washington rumor mill, Representative Tom Foley has so far refused to schedule floor debate in the House on health system reform until the Senate Finance Committee reports out a bill. Political pundits say Foley and other House members are reluctant to be "BTUed", a reference to the fact that House members were left out on a limb after they made a difficult decision to publicly support a BTU tax only to have the proposal scuttled by the Senate.

Foley and other representatives feel that any bill reported out of the Senate Finance Committee will be supported by the full Senate.

Worth Repeating

"The great imperative is to control spending. If we don't, most of the problems will slowly worsen — even if we create universal insurance. The president has never made this clear."

Robert Samuelson, in a *Newsweek* column entitled "Salesmanship Isn't Leadership".

Glossary of health system reform terms

Administrative costs — Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance activities, medical libraries and risk management.

Basic benefits package — A core set of health benefits that everyone in the country should have, either through their employer, a government program or a risk pool.

Community rating — Premiums based on the potential health risks or claims experience of the entire population in an area.

ERISA — The Employee Retirement Income Security Act. ERISA exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state health reforms.

Fee disclosure — To improve cost consciousness, the IMS supports physicians discussing with patients their charges prior to treatment.

Global budgets — Limits on categories of health spending. The IMS opposes global budgets as arbitrary limits that reduce access while ignoring underlying systemic problems.

GNP — Gross National Product. The dollar value of all goods and services produced by a country. In 1990, US health care spending was 12% of GNP.

Health IRAs — Proposed tax-deferred plans to encourage saving for future medical expenses. Funds in health IRAs could be later cashed out for medical expenses.

Job lock — The inability of individuals to change jobs because they would lose crucial health benefits.

Managed competition — A health insurance system that would band together employers, labor groups and others into insurance purchasing groups. Employers and other collective purchasers would make a set contribution toward purchase of insurance for individuals they represent. The set contribution acts as an incentive for insurers and providers to compete.

National health expenditures — Total spending on health services, prescription and over-the-counter drugs and products, nursing home care, insurance costs, public health spending and health research and construction. In 1992, US health expenditures were estimated at over $800 billion.

Play or pay — Employers would be required to provide health insurance to their employees or pay a special government program tax.

Portability — An individual changing jobs would be guaranteed coverage with the new employer without a waiting period or having to meet additional deductible requirements.

Practice parameters — Strategies for patient management, developed to assist physicians in clinical decision-making. The IMS supports physician-developed parameters which improve quality and assure appropriate utilization of health services.

Preexisting condition limitations — A provision in insurance policies that excludes health conditions existing prior to coverage sign up. These limitations exclude specified conditions entirely or for a specified period. When an individual changes jobs and enrolls in a new insurance plan, these limitations can cause a critical gap in health benefits.

Risk pools — Programs created by the legislature which group individuals who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues.

Small market insurance reform — Changes in the marketing of insurance to small businesses that increase the availability and affordability of coverage. The IMS worked successfully in the Iowa Legislature for market reforms that eliminate preexisting condition limitations for employees of small businesses, institute modified community rating and make health insurance portable.

State mandated benefits laws — State laws requiring insurance contracts to provide coverage for certain health services (such as in vitro fertilization) or for services provided by certain health care providers (such as audiologists). There are over 800 mandates nationwide. The IMS opposes all mandates and supports repeal of these laws and establishment of a federal basic benefits package.

Tax incentives — Tax deductions, credits and rebates affecting insurance benefit decisions. The IMS supports tax changes to help small businesses.

Uniform claim form — All insurers and self-insurers would be required to use a single claim form and standardized format for electronic claims. The IMS worked successfully in the Iowa Legislature for a uniform claim form as a way to reduce administrative costs. IM

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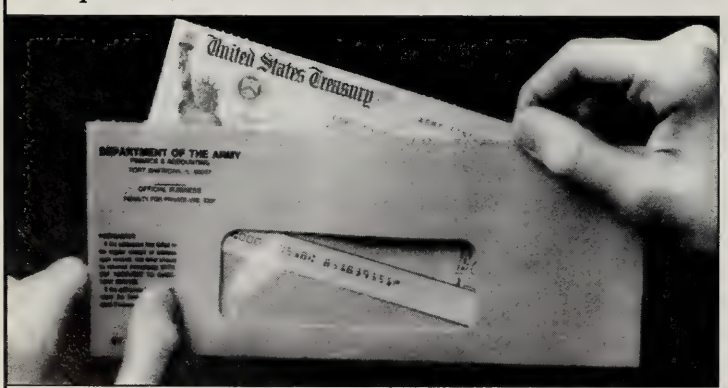
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Legislative Affairs

Legislature deals with reform-related issues

While a comprehensive health system reform bill was not passed by the Iowa Legislature this year, the legislature passed several significant bills relating to reform. Equally significant is the fact that the House of Representatives wisely chose not to pass potentially damaging legislation received from the Senate.

The following health system reform components were approved by the legislature.

CHMIS: The Community Health Management Information System bill, SF 2069, was approved and has been signed by the governor. The bill sets up an electronic system of claims processing and data collection using information from the claims form. A uniform claims format will be required to be used by all insurers doing business in Iowa. Signed by governor.

Access to State Fiber Optic Network: The final version of SF 2089 allows access for physicians' clinics and hospitals to the state fiber optic network for the purpose of telemedicine. Before physicians and hospitals are able to hook up to the system administrative rules will be adopted outlining specific requirements.

Rural Health Care: HF 2422 establishes a Center for Rural Health and Primary Care within the Iowa Department of Public Health (IDPH). The Center will encourage collaborative local efforts to adopt health services plans, coordinate services relating to rural occupational health issues and establish programs for recruitment and retention, primary care provider loan repayment, community scholarships and community grants.

The bill also requires the IDPH to establish area health education centers (AHECs) in cooperation with the University of Iowa College of Medicine, the University of Osteopathic Medicine and Health Sciences and other educational institutions. The AHECs are intended to provide education opportunities for primary care providers, consultation and access to medical libraries and resources.

Employer Conduit: SF 2282 will require employers to offer their employees access to health benefits, although the employer will not have to pay for those benefits. The bill also requires community rating for the basic and standard benefit plans provided for under small group insurance laws.

Problematic Bill Not Debated: The Senate-passed health system reform bill, SF 2222, was not debated in the House. The bill contained a provision which would have caused significant disruption in the insurance industry and would have increased health insurance costs, providing a further disincentive for employers to provide insurance.

The bill would have required managed care plans or indemnity plans with a limited provider network to provide direct patient access to the following practitioners: primary care MDs and DOs, physical therapists, occupational therapists, physician assistants, podiatrists, chiropractors, nurses, dieticians, dentists, optometrists, psychologists and pharmacists. However, access to specialist physicians could be restricted. (The Senate committee version of the bill listed even more practitioners.)

The IMS and other key organizations including the Iowa Hospital Association, the Association of Business and Industry and the Iowa Farm Bureau Federation, strongly opposed this provision as well as other aspects of the bill. House leadership made the correct decision not to debate this bill and to deal with health system reform issues in another form. Several components of the governor's original recommendations were passed separately.

Other Issues

Final action on many key issues was covered in the April issue of *Iowa Medicine*. Following is an update on other issues of interest.

Helmet Law: The helmet law did not receive consideration in either house.

Appropriations — Board of Medical Examiners: HF 2376. Both House and Senate have

continued

AT A GLANCE

IMS physicians are represented on the Iowa Telemedicine Advisory Council, which is studying physician and hospital access to the state fiber optic network. Watch for more information in upcoming issues of Iowa Medicine.

The importance of grass roots contact with legislators was demonstrated during the closing weeks of this year's legislative session. Physician contacts with local legislators helped them understand problems associated with the health system reform bill which was fortunately not brought up for debate in the Iowa House during this session.

The US House Ways and Means health subcommittee has approved a new federal tax hike on cigarettes of $1.25 per pack. President Clinton has proposed an increase of 75 cents; the tax is now 24 cents.

Legislative Affairs

continued

adopted a funding level of $979,949 for the fiscal year beginning July 1, 1994. This compares to $966,939 appropriated for the fiscal year beginning July 1, 1993 and ending June 30, 1994. HF 2376 also contains appropriations for the Department of Public Health and the Department of Human Rights.

Medicaid: SF 2313. Both the House and Senate approved the governor's recommendation for a 10% increase in Medicaid reimbursement for obstetrical care and 5% for Early and Periodic Screening, Diagnosis and Testing (EPSDT) for children. No increase was approved for other physician services.

University of Iowa College of Medicine: HF 2411. Both houses approved $330,000 for family practice faculty and support staff in the College of Medicine and $300,000 for additional primary care initiatives.

HIV Studies: HF 2353 has been approved to allow the Iowa Department of Public Health to perform nonblinded HIV studies subject to legal requirements relating to such issues as pretest counseling, consent of the individual to testing, etc. Funding availability will determine whether any studies are performed. Signed by governor.

Mandatory Physician Assistant Coverage: SF 2211 would have required health insurance companies to provide payment for services provided by a physician assistant within the PA's scope of practice if the same services are covered when provided by a physician. This bill passed the Senate but was not debated by the House. Amendments were filed in the House to extend the same mandate to services provided by nurse practitioners, nurse anesthetists and podiatrists.

Department of Public Health Recommendations: HF 2145 makes a variety of mostly technical changes. Changes include requiring a child to be vaccinated for haemophilus influenza b to enroll in a licensed child care center and eliminating the requirement that physicians report brain injuries. Hospitals will continue to report brain injuries resulting from trauma or anoxia which impair physical or cognitive functions. Signed by governor.

Parental Notification of Abortion: The House passed HF 2012 requiring that a parent be notified before a minor receives an abortion (except in medical emergencies, if a parent has provided a written authorization in advance, in the case of a pregnancy resulting from incest, or if the court authorizes waiver of the notification requirement). Despite efforts of supporters, the issue was not debated in the Senate.

Contact Lens Prescriptions: HF 2309 provides that only a person who possesses a written contact lens prescription for a patient may dispense contact lenses to that patient. After fitting and follow up care for contact lenses is completed, a patient may request a copy of the prescription from the optometrist or opthalmologist. Optometrists and ophthalmologists are also required to provide a copy of an eyeglass prescription to a patient. This bill is intended to clarify whether contact lenses can be provided directly to a patient without a prescription, such as through mail order houses. Signed by governor.

Mental Health: Several bills relating to mental health issues have been considered.

HF 2037 requires that a summary of involuntary commitment proceedings be provided to the applicant. Signed by the governor.

HF 2134 requires the court to permit the patient advocate for the respondent's county of legal settlement to attend involuntary commitment proceedings. Signed by governor.

HF 2236 limits a minor's right to object or consent to voluntary treatment for substance abuse or mental illness to minors age 14 or over. Current law sets no specific age of consent. HF 2236 died in the Senate.

HF 2430 provides a formula for funding of mental health, mental retardation and developmental disabilities services. Cost containment measures such as managed care and single point of entry are included.

SF 2319, the juvenile justice bill, contains a section providing that "sexually violent predators" could be removed from the state correctional system and sent to a mental health institute until they are no longer a danger to society.

The intent is to protect the public from criminals who may be leaving prison, but the language of the amendment appears to allow violent criminals to transfer during the course of serving a sentence from a correctional institution such as the one at Fort Madison to a mental health institute or other facility operated by the Department of Human Services.

Under this approach, the incarceration of some criminals could be extended well beyond their sentences. This part of the bill will not be implemented until July, 1995. IM

The bill provides that "sexually violent predators" could be removed from the state correctional system and sent to a mental health institute.

Medical Economics

More bad news from up North

The IMS is receiving reports from member physicians that the state of Minnesota is attempting to make them pay a retroactive surcharge on licenses to practice in that state.

The MinnesotaCare Act imposes a $400 surcharge on physician licenses to help fund health system reform. (According to the Minnesota Board of Medical Practice, the surcharge brings the cost of a Minnesota license to $568.)

The Minnesota Legislature made the surcharge retroactive and Iowa physicians who wish to maintain Minnesota licenses are being billed for the charge if they renewed a Minnesota license from April 1-September 30 of 1992. One Iowa physician was reported to a collection agency for failure to pay the surcharge.

The Minnesota Medical Association has filed a class action lawsuit against the state of Minnesota on behalf of physicians who renewed Minnesota licenses during that time on the grounds the surcharge is retroactive for physicians who had already paid 1992 license fees.

The Minnesota Practice Board says only 77 Iowa physicians still hold Minnesota licenses.

Outpatient prospective payment system

Effective October 1, 1994, the Department of Human Services will reimburse outpatient services to Medicaid recipients using a Prospective Payment System (PPS) referred to as Ambulatory Patient Groups (APG).

The new system is designed to address the hospital's cost for providing care (room charges, medical and surgical supplies, etc.) while excluding the physician's professional service.

The APG classification system for outpatient care serves the same function as DRGs in the inpatient hospital setting. There are 297 APGs which breaks down to 145 procedure APGs, 80 medical APGs and 72 ancillary service APGs. The APGs describe all patient types (not just Medicare) and can thus be used by state Medicaid programs and other non-Medicare payers.

The APGs were developed with extensive physician input. For more information, call Donna Bottorff at the IMS, 800/747-3070.

OSHA's tuberculosis guidelines

Since 1985, the rate of new cases of tuberculosis has increased 18%, reversing a 30-year downward trend. In 1990, 25,000 new cases were reported. Recently, drug resistant strains of TB have become a serious concern.

The following guidelines for early detection and prevention of TB were developed by OSHA. Following is basic information needed by medical personnel likely to be exposed to TB.

What causes tuberculosis?

TB is caused by the bacterium Mycobacterium tuberculosis, which is generally spread through respiratory secretions when a person coughs, speaks, etc. Symptoms include cough, fever, weight loss, night sweats, anorexia or chest x-ray changes.

Who is at risk for TB?

Factors which indicate an increased risk for TB include lower socioeconomic status, crowded living conditions and inadequate nutrition. Elevated TB rates have been found in prison inmates, alcoholics and IV drug users. Specific demographic groups have also experienced increased TB, including the elderly, African-Americans, Asians, Pacific Islanders, American Indians, Alaska natives, Hispanics and people from areas with high TB prevalence.

How is TB testing performed?

The Purified Protein Derivative (PPD) TB skin test is a standard preparation of proteins and other materials assessed at 48-72 hours after intradermal injection. Interpretation of test results depends on age and medical status and should be done by a licensed health care professional. The Centers for Disease Control has established guidelines for TB skin testing. Periodic chest x-rays are not recommended for TB screening or surveillance.

continued

AT A GLANCE

The AMA has available a new publication entitled "A Physician's Guide to Selecting and Working with a Managed Care Attorney or Consultant." The document is free to AMA members by calling AMA customer service at 800/621-8335, order number OP 631193MD.

Midwest Medical Insurance Company is urging its Iowa insureds to participate in a national letter-writing campaign in support of malpractice reform. It is hoped many of the 200,000 physicians insured by 44 liability companies will write letters to Congress.

Medicare trustees told Congress the fund will run dry by 2001 unless there are cost-containment measures and adjustments in the tax structure. In contrast, the Social Security long-term budget looks healthy.

Medical Economics

continued

Who should receive preventive therapy?

One in 10 people infected will develop TB unless they undergo preventive therapy. It should be given to high risk patients following a PPD conversion or a positive PPD with no history of TB or TB immunization. High risk individuals include those with HIV, close contacts of TB patients, IV drug users, people with previously untreated or inadequately treated TB and those with conditions increasing the risk of TB. Preventive therapy following PPD conversion or a positive PPD with no prior history of TB or TB immunization should be offered to the risk groups listed previously if they are under 35 years of age.

Where will OSHA inspect for TB?

CDC has identified five types of facilities where there is a greater incidence of TB. These are in-patient health care settings, correctional institutions, homeless shelters, long-term care facilities for the elderly and drug treatment centers. Physician's offices will not be inspected unless a complaint is received.

All physician labs must notify the Department in writing of any changes in ownership, name, location or director.

CLIA notification requirements

At the suggestion of several physician office laboratories, the Iowa Department of Inspections and Appeals has contacted the IMS to provide educational information regarding the Clinical Laboratory Improvement Amendments (CLIA). The Department is responsible for CLIA implementation and contracts with the U of I Hygienic Laboratory for survey personnel.

Under CLIA, all physician laboratories must notify the Department in writing within 30 days of any changes in ownership, name, location or director. In labs performing highly complex testing, any change in lab supervisor must also be sent to the Department.

Laboratories must also notify the Department within six months of additions of 1) tests or examinations within a specialty or subspecialty previously not included on the lab's certificate; or 2) deletions or changes in test methodologies for any test or examination included in a specialty or subspecialty for which the lab has been issued a certificate.

All changes affecting a lab's certificate should be sent to: Nancy Ruzicka, Iowa Department of Inspections and Appeals, Division of Health Facilities, Lucas State Office Building, Des Moines, Iowa 50319. Physicians may call the Iowa Department of Inspections and Appeals, 515/281-4120, with questions. IM

Reducing Taxes with Tax Credits

Q. I keep reading about tax credit programs and how effective they are at reducing taxes. Can you tell me more about them?

A. One of the most effective and frequently overlooked ways of reducing federal tax liability is the Low Income Housing Tax Credit (LIHTC). Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

Investors typically receive tax credits equal to approximately 150% of their investment spread out over 10 years. So a $5,000 investment would yield tax savings of approximately $750 per year for the next 10 years, for a total of 7, 500. Depending on factors such as income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using LIHTC.

In addition to the credit there is potential for cash flow distributions in many programs. Generally all cash flow paid to investors is completely sheltered from taxes as well. Finally, when the properties in the portfolio are sold, they may be sold at a profit. Again a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The dollars raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. It is important to note that these are not crime infested, graffiti covered intercity housing projects. They are primarily new construction, garden-style suburban and rural apartment buildings.

The alternative to using LIHTC is simply to pay your taxes. For that you get no liquidity, no return and your holding period is forever. By using credits, you redirect dollars that would have been used to pay taxes back into your pocket to add to your net worth. This is why these programs are so widely used by corporations and individuals.

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Practice Management

Requirements for hearing-impaired patients

The Americans with Disabilities Act, a sweeping civil rights measure enacted in 1992, contains a requirement that all public accommodations furnish and pay for auxiliary aids and services to ensure effective communication with people who have impaired hearing or vision. This includes physicians' offices.

Physicians should consider use of a qualified interpreter, Braille materials or other devices for effective communication with patients whose hearing is impaired.

Physician offices may use telecommunications devices for deaf persons established under the ADA for incoming calls to their offices or for communicating by phone.

Since a physician's office is considered a public accommodation, the patient cannot be charged for provision of an auxiliary aid. However, you may recoup part of your costs through a tax credit.

The aid requirement is flexible; physicians can choose among various alternatives as long as the result is effective communication.

The ADA requires a public accommodation to consult with the individual before providing an auxiliary aid or service but does not mandate use of an interpreter for every appointment with a hearing-impaired patient or every time a patient requests a service.

Physicians should use their best judgment about the patient's needs and when the service would be effective and appropriate. (A specific example given in the ADA regulations is a discussion with a patient about whether major surgery is needed.)

Under the ADA, a qualified interpreter is "an interpreter who is able to interpret effectively, accurately and impartially both receptively and expressively, using necessary specialized vocabulary." The regulations are specific about certain circumstances where family members or friends of the patient may not be qualified.

Physicians may recoup part of their costs of compliance through a tax credit. The practice must have less than $1 million in gross receipts for the preceding tax year or fewer than 30 full-time employees.

The tax credit may be an amount equal to 50% of the expenses incurred for the tax year (an amount between $250 and $10,250). Physicians are advised to discuss tax credits for ADA compliance with an accountant.

(In next month's **Practice Management**, a hearing-impaired patient will discuss problems which can occur during a visit to a physician.)

Resources for hearing-impaired patients

1/800-735-2943 — Outgoing phone line the public can use as a relay service when trying to reach a hearing-impaired person. Your office may use this when trying to phone a patient or family member. Consider confidentiality issues when using this phone line for purposes other than appointment scheduling.

continued

AT A GLANCE

According to Blue Cross/Blue Shield, effective immediately, you may report ICD-9-CMV-codes in accordance with the ICD-9-CM Outpatient Hospital Service guidelines. BCBSI's system will now recognize V-codes in form locators 67-75 on the UB-92 claim form. Call a provider service representative at 245-4688 or 800/362-2218 with questions.

If you are employed in a medical office or clinic and want to further your professional development and get formal recognition for it, the Iowa Medical Society's Medical Business Specialist Certificate Program is for you. Call Barb Cannon or Sherry Johnson, 515/223-1401 or 800/747-3070 for details.

Upcoming Workshops for You and Your Practice

• Quality in the Practice
Tues., June 14, 9 am - 4 pm
St. Luke's Hospital, Cedar Rapids
AND
Wed., June 22, 9 am - 4 pm
IMS headquarters
West Des Moines

•Office Safety and Compliance
Mon., June 20, 1 - 4:30 pm
St. Luke's, Sioux City
AND
Tues., June 21, 9 am - 12:30 pm
North Iowa Mercy Health Center
Mason City

• ICD-9-CM Coding
Wed., June 15, 9 am - 4 pm
St. Luke's, Cedar Rapids

• CPT-4 Coding
Thurs., June 16, 9 am - 4 pm
Mercy Hospital, Cedar Rapids

•Medical Terminology
Thurs., June 23, 9 am - 4 pm
IMS headquarters, WDM

For more information about any workshop or seminar, call Barb Cannon or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

Practice Management

continued

800-735-2942 — Incoming telephone line that can be used by the hearing-impaired to call public accommodations through the use of a telecommunication device for the deaf. A phone operator will relay to you the message that has been typed by the hearing impaired patient at the other end.

515/281-3164 — Deaf Services of Iowa, which has qualified interpreters available for hearing impaired patients in Iowa. Deaf Services of Iowa has offices in Des Moines (281-3164); Council Bluffs (712/328-3195); Davenport (319/322-0255); and Fort Dodge (515/955-2539).

515/266-5105 — Deaf Action Center of Des Moines, which has interpreters, predominately for the central Iowa area. This center also sponsors sign language classes.

For office questions related to the ADA, call Dave Furneaux at the Iowa Medical Society, 800/747-3070 or 515/223-1401. IM

For more information on medical records, consult the Iowa Medical Society's 'Physician's Guide to Medical Records' which appeared in the January issue of *Iowa Medicine.*

MIDWEST MEDICAL INSURANCE COMPANY
FOCUS ON RISK MANAGEMENT

Releasing medical information

The confidentiality of the patient's medical record is the crux of patient trust. Disclosure of information to an unauthorized party by anyone in your practice may result in liability or disciplinary action for the physician.

Here are answers to common questions received by MMIC staff:

- Patients have a right to information about their health status. Copies of their records should be provided at the patient's request, but never release original records.
- Original x-rays should be considered part of the medical record. Copies should be provided for release. If you cannot produce copies, institute a tracking system to ensure return of the x-rays.
- Written authorization by the patient or guardian should be obtained before information is released. Specific consent must be obtained for information concerning HIV or mental health or substance abuse treatment.
- A subpoena for records does not automatically mean the physician should release the record because the subpoena's validity may be challenged. Legal counsel or involvement of the patient may be necessary.

For more information contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

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Newsmakers

Research study at Iowa City VAMC

Dear Editor:

The purpose of this letter is to request your aid in locating the veterans listed below. These veterans may provide valuable information for a research study being conducted at the Iowa City Department of Veterans Affairs Medical Center (VAMC). Only partial information is known on each of the veterans, however, all of the veterans served in the Vietnam War and were seen at the 93rd Evacuation Hospital in Long Binh, Vietnam in 1966.

Letter to the Editor

These veterans are: Willie Blaine, Ronald Carlson, Melvin Clarke, Raymond Derby, David Fuller, Ernest Fritel, Gary Johnson, Thomas Kirk, McDonald (first name unknown), James Meinke, Alex Mere, Johnie Miller, Robert Newsome (possibly Newson), Louis Nordeen, Albert Paglia, Michael Sparr, Storey (first name unknown) and Jose Yepez.

Anyone with information or questions pertaining to this request may contact Annie Tuttle, public affairs specialist, at 319/338-0581 (extension 6206) or Dr. Richard Roberts, chief, Psychology Service at extension 6000. Toll free numbers are 800/637-0128 (within Iowa) and 800/346-1843 (outside Iowa).—*Annie Tuttle, Iowa City, Iowa.*

Awards, appointments, etc.

Dr. Marion Alberts, retired pediatrician from West Des Moines, was recently recognized at the United Way of Central Iowa 1994 Volunteer Recognition Dinner. Dr. Alberts was nominated by Living History Farms for his contribution as the Victorian mansion gardener. **Dr. Stephen DeVore** has joined **Dr. Stanton Danielson** in practice at the Altoona Family Care Center. **Dr. Michael Stefan** has joined **Dr. Eugene Cherny** in practice at Heartland Plastic/Reconstructive Surgery, Des Moines. **Dr. Charles Helms**, UI professor in the Department of Internal Medicine, UI College of Medicine, has been selected as chairman of the Public Policy Committee of the Infectious Diseases Society of America. His term is for three years. **Dr. Edmund Franken, Jr.**, professor and head of the Department of Radiology, UI College of Medicine, has resigned as head of radiology, effective June 30. Dr. Franken will remain on the UI faculty. **Dr. Wilbur Smith**, professor of radiology, has been named interim head of the department. Funds generated in honor of Doctors' Day (March 30) totalling $2,430 will go to American Medical Association Education and Research (AMA-ERF). The AMA-ERF provides grants to medical schools for student financial aid and funds student research. The following physicians and groups were honored: **Drs. John Anderson, Robert Bannister, James Bell, Fred Carpenter, Jr., James Delperdang. Kathleen Foster-Wendel, David Gerbracht, Philip Habak, Paul Holzworth, Thomas Johnson, James Kimball, Richard Myers, James Piros, Richard Reams, Bruce Trimble, Joseph Veverka, David Wall, Jim Carr, Garry Cole, Greg Halverson, Joseph Peraud, Mary Peraud, Richard Reams**, St. Lukes's Hospital (Davenport), North Iowa Mercy Health Center (Mason City), Allen Memorial Hospital (Waterloo), Marshalltown Medical and Surgical Center and Mercy Hospital (Davenport). The Iowa Medical Society Alliance also sponsored a "Non-run Marathon" to raise money for the AMA-ERF. Top contributors were **Hermina Habak, Martha Holzworth, Barbara Bell** and **Kitty Myers.**

Deceased members

Rosalie Neligh, MD, 77, life member, internal medicine, Council Bluffs, died March 25

Clarence Phillips, MD, 98, life member, general practice, Muscatine, died April 6

John Scott, MD, 67, pathology, Sioux Ciy, died April 3 IM

AT A GLANCE

***R. Edward Howell** has been named chief of UI Hospitals and Clinics, Iowa City, effective August 1. Mr. Howell currently is executive director of the Medical College of Georgia Hospital and Clinics in Augusta.*

IMS member physicians have the opportunity to advertise their practices in a special section of the 1994-95 IMS Membership Directory which will be published in October 1994. For details call Jane Nieland or Bev Corron at IMS headquarters, 515/223-1401 or 800/747-3070.

Cancer Pain MANAGEMENT: 'inadequate'

The tools and techniques needed to manage pain in a vast majority of cancer patients are readily available but are not being used effectively, say these Iowa internists. For patients with advanced malignancies, the most satisfying role physicians can play is to provide effective pain management.

ROBERT DREICER, MD
DEAN GESME, JR., MD
Dr. Dreicer is an internist with the University of Iowa College of Medicine; Dr. Gesme is an internist practicing in Cedar Rapids. Both physicians are on the board of directors of the Iowa Cancer Pain Relief Initiative.

Cancer pain management in the United States remains so woefully inadequate it is little wonder the public is so fascinated by the activities of Dr. Jack Kevorkian. The physician's perspective on this problem emerged in the results of a study recently published in the *Annals of Internal Medicine*.

Cancer physicians with patient care responsibilities (medical oncologists, hematologists, surgical and radiation oncologists) who participate in the Eastern Cooperative Oncology Group (ECOG) were asked to respond to a physician cancer pain questionnaire developed by the Pain Research Group at the University of Wisconsin. The questionnaire was designed to assess physicians' estimates of the magnitude of pain as well as the adequacy of cancer pain treatment in their own practices.

Of 900 responding specialists, 86% believed the majority of patients with pain are undermedicated. Only 51% of physicians said pain control was good or very good in their own practice. Thirty-one percent of physicians said they wait until the patient's prognosis was six months or less before starting maximal analgesia. Seventy-six percent of physicians said adequate pain assessment was the single most important barrier to adequate pain management.

86% believe the majority of patients with pain are undermedicated.

There is good news, too

These results from a survey of cancer physicians highlights the magnitude of the problem we face to ensure that our patients receive appropriate pain management. This explains the fascination of the media and the public with the issue of legalized euthanasia.

There is good news. All the tools necessary to alleviate cancer pain for the vast majority of patients are readily available. The only major impediment to cancer pain relief is a widespread misunderstanding of pain management principles by the medical profession.

A primary obstacle to appropriate utilization of opioids is the fear among clinicians and patients alike of addiction and substance abuse. Given this widely-held misconception, a brief discussion of physical

HERE'S TO YOUR Health

A patient's guide to better health
Provided by the Iowa Medical Society

Prostate cancer

What is the prostate?

The prostate is a male genital gland about the size of a chestnut. It secretes a milky fluid that is part of the semen needed for ejaculation. The prostate gland lies at the base of the penis, just below the urinary bladder and above the rectum. The prostate surrounds the upper portion of the urethra, the tube that carries urine out of the bladder.

Is prostate cancer becoming more common?

Because men are living longer these days, prostate problems are becoming as common as graying and balding. Cancer of the prostate is the most common type of cancer among American men and the second leading cause of cancer deaths among them. The average age for developing prostate cancer is 72 and it rarely occurs in men younger than 50.

Prostate cancer is one of the slowest-growing types of cancer and can usually be controlled.

What are the risk factors for prostate cancer?

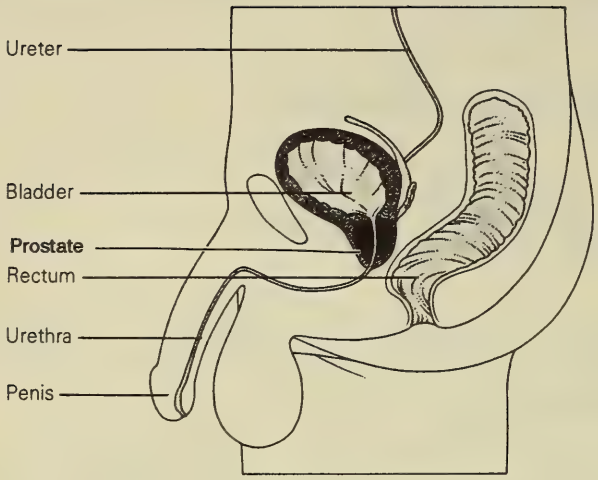
The cause of prostate cancer is unknown. However, several factors have been identified with a higher rate of prostate cancer. The most crucial factor is age. Nearly all patients with prostate cancer are more than 55 years old and 80% are over age 65.

New studies suggest that diet and nutrition may play a role and that a low-fat diet may help reduce the risk of developing prostate cancer.

How can I tell if I have prostate cancer or a less-serious problem?

Prostate cancer often doesn't produce symptoms, especially in the very early stages. Most malignant tumors develop in the outer portion of the prostate and don't

Insert to *Iowa Medicine*, June 1994



press on the urethra. When symptoms develop, they vary according to the size and location of the tumor and are often the same as those for benign prostate conditions. In fact, it is more likely any of these symptoms indicate prostate enlargement, infection or other conditions.

Recent studies suggest an enlarged prostate alone is not enough reason to get treatment and could be Benign Prostate Hyperplasia —BPH — rather than cancer. BPH causes frequent and urgent urination and a sensation that the bladder never quite empties. It is unrelated to prostate cancer.

What are the symptoms of prostate cancer?

The symptoms include:

- Weak or interrupted urine flow.
- Inability to urinate or difficulty in starting or stopping urination.
- Need to urinate frequently, especially at night.
- Blood in the urine.
- Painful or burning urination.
- Continuing pain in lower back, pelvis or upper thighs.

When difficulty or pain on urination develops, it's time to see your physician. You can go to your family physician, but you may be referred to a urologist, a physician who specializes in treatment of disorders of the urinary and male genital systems.

How are prostate problems diagnosed?

There are three main tests used in establishing a diagnosis:

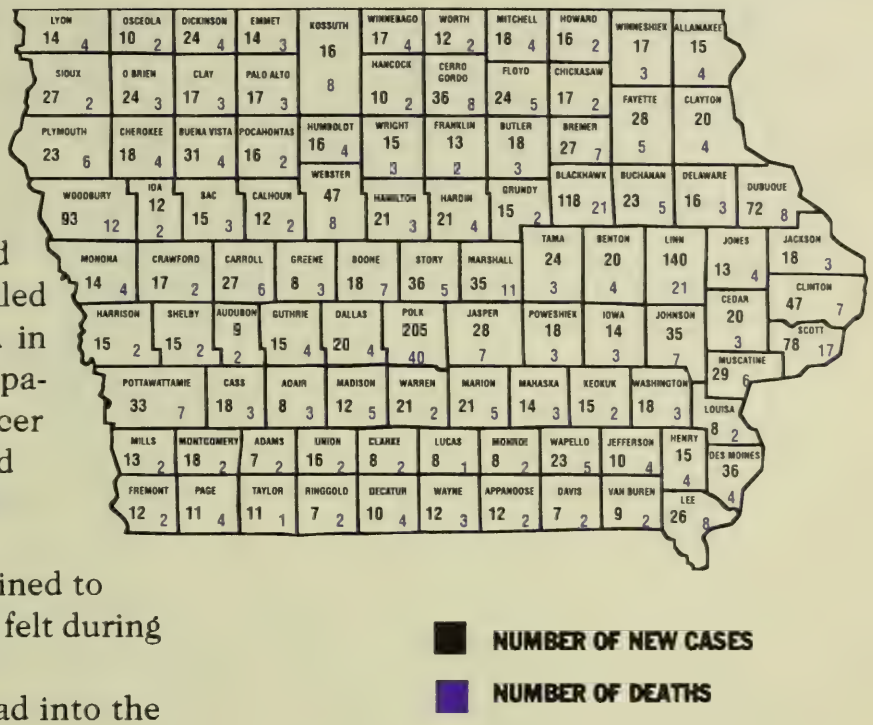
- **Intravenous pyelogram** — X-ray of the urinary tract.
- **Cystoscopy** — Internal examination of the bladder and prostate done with a cystoscope.
- **Needle biopsy** — Surgical removal of a tissue sample done in the doctor's office with a local anesthetic or in the hospital.

Which tests are used and the sequence in which they are done will be decided by your physician.

What are the stages of prostate cancer?

Treatment of prostate cancer and the expected outcome vary greatly on the stage or extent of the disease. Newly-diagnosed cases generally fall into one of these stages:

ESTIMATED NUMBER OF NEW PROSTATE CANCERS AND DEATHS, 1994
Source: State Health Registry of Iowa



•**Very early** — The cancer is confined to the prostate gland and cannot be felt during a rectal examination. This is usually detected in patients having surgery for what was thought to be benign prostate disease but whose biopsy reveals cancer. In many cases, patients with very early cancers receive no additional treatment but are advised to return for regular examinations. This is called "watchful waiting". Recent studies reported in the *New England Journal of Medicine* suggest patients with localized early stage prostate cancer have a relatively good prognosis when treated with watchful waiting, particularly when the patient's life expectancy is 10 years or less.

•**Localized** — These cancers are still confined to the prostate gland but are large enough to be felt during a rectal examination.

•**Regionalized** — These tumors have spread into the tissues immediately surrounding the prostate gland.

•**Advanced** — In this stage, tumors have spread to the lymph nodes in the pelvis or beyond, or to other body structures, usually the bones.

How is prostate cancer treated?

Treatment depends on the stage of the disease, the age of the patient, the anticipated effects of the treatment and the patient's overall health and expected lifespan. An older man in poor health may choose not to undergo treatment that could cause unpleasant side effects but not lengthen his expected longevity.

In most cases of prostate cancer, treatment will include one or more of the following therapies:

•**Surgery** — A cancer confined to the prostate can usually be successfully treated by surgical removal of the gland (total prostatectomy).

•**Radiation** — Cancers confined to the prostate or that have spread only to surrounding tissue can be cured by radiation, either external or internal. For patients with later stage disease, radiation may be used to reduce the size of the tumor and provide relief from symptoms. The external beam radiation is usually done on an outpatient basis. If internal radiation is the treatment of choice, tiny pellets of radioactive isotopes of gold, iodine or iridium

are implanted directly into the prostate. Too small to cause discomfort, these pellets emit radiation for about a year and can safely remain in place afterwards.

•**Hormone treatment** — Most prostate cancer cells need testosterone to grow. There are several types of hormone therapy to slow the growth and spread of these cells by reducing the amount of testosterone circulating in your body. Hormone therapy is the main treatment for metastatic and recurring prostate cancers causing symptoms such as bone pain and bladder obstruction. (However, starting hormone therapy before symptoms occur has not been shown to be of any benefit.) You may receive a form of the female hormone estrogen or your testes — the major producer of testosterone — may be removed.

•**Chemotherapy** — Chemotherapy can reduce pain and other symptoms of advanced prostate cancer and slow tumor growth. Its use in earlier stage disease, alone or combined with other treatments, is being studied.

What are the treatment side effects?

Side effects of prostate surgery include some degree of impotence due to unavoidable nerve damage; 5-15% of surgery patients have urinary incontinence.

Side effects of external beam radiation include impotency in 30-50% of patients within two years of treatment. Less than 30% of patients receiving internal radiation experience erectile impotency.

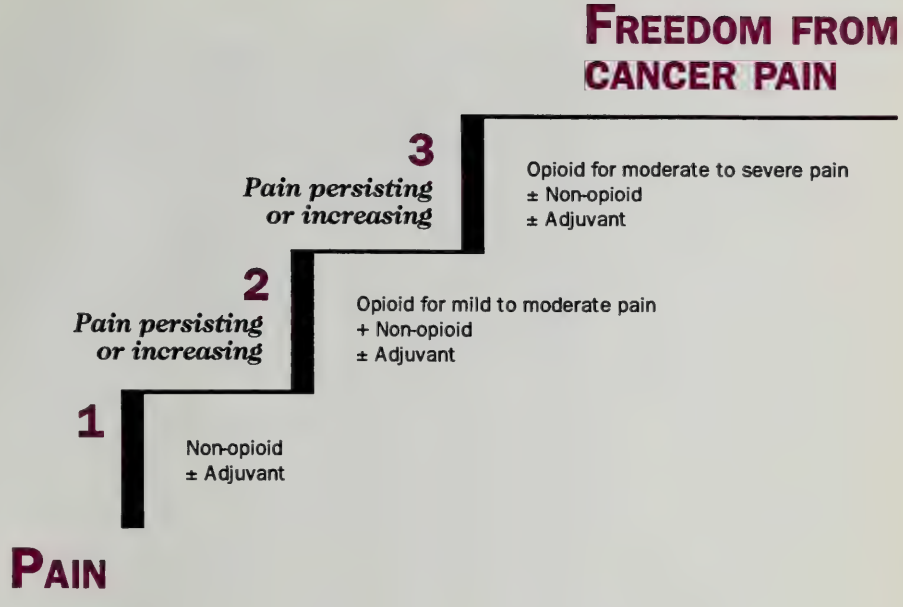
Side effects of hormone therapy include breast enlargement, water retention and impotence or loss of sex drive.

Side effects of chemotherapy include nausea, hair loss, anemia, reduced blood clotting ability and increased likelihood of developing infections and mouth sores.

What is the prognosis for prostate cancer?

Survival rates for all stages of prostate cancer have steadily improved. In the last 30 years, the over 5-year survival rate for all stages has risen from 50% to 76%. For cancers confined to the prostate or the general prostate region (60% of all prostate cancers diagnosed), the survival rate is even more reassuring. Ninety-one percent of these patients are alive five years or more after diagnosis.

This information on prostate cancer has been compiled from information published by the American Cancer Society, the American Foundation for Urologic Disease and the Iowa Cancer Registry. Original inserts may be purchased from the IMS for 15 cents each. Call Jane Nieland or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.



dependence, psychological dependence (addiction) and tolerance is in order.

Defining addiction

Physical dependence is defined by the phenomenon of withdrawal when an opioid is abruptly discontinued or an opioid antagonist is administered. This must be contrasted with psychologic dependence (addiction). Psychologic dependence can be defined as a pattern of drug use characterized by a continued craving for an opioid manifested as compulsive drug-seeking behavior.

In the past decade the expanding role of cancer pain units at various institutions has provided a setting in which large numbers of patients have received narcotics for prolonged periods. This experience has demonstrated several critical points. In fact, experience has shown patients can be physically dependent on narcotics without evidence of psychologic dependence or addiction.

Several studies have described the use of chronic opioid therapy in patients with nonmalignant pain and have reported their effective use is not associated with addiction. While prospective studies in cancer patients are not available, a large, broad-based clinical experience is consistent with the statement that cancer patients use opioids to control pain, and when the pain has resolved the narcotic use ends.

Tolerance is the pharmacologic effect in which, with repeated administration, higher doses are necessary to achieve the same effect. Tolerance develops at different rates for each of the various opioid effects. Tolerance to the constipating action of narcotics appears never to develop. However, tolerance to the respiratory effects of narcotics develops very rapidly.

With regards to achieving effective analgesia, there appears to be no limit to tolerance. Escalating doses can be used to provide all patients with effective analgesia.

Little attention in training

The principles of cancer pain management receive little attention in most medical schools and academic training programs. As a consequence most physicians acquire experience with management of acute pain and then extrapolate those principles to the patient with cancer pain, frequently with poor results. As with all medications, physicians have established a definite "comfort zone" for prescribing drug doses and do not like to vary from it.

In a report of the doses of parental morphine required during 24 hours in 100 cancer patients in the Memorial Sloan Kettering Cancer Center Continuity of Care Program, 34% required doses greater than 300 mg per day. Thirteen percent of patients required greater than 2,000 mg per 24 hours.

Dr. Kathleen Foley a renowned pain management expert has written that "...tolerance remains a poorly understood phenomenon in

WE'D LIKE TO HEAR YOUR OPINION

Do you have an opinion about whether pain in cancer patients is managed effectively by Iowa physicians? If so, put it on paper, send it to us and we will publish it in an upcoming *Iowa Medicine*. Send your replies to: *Iowa Medicine*, 1001 Grand Avenue, West Des Moines, IA 50265.

RECOMMENDED CLINICAL APPROACH TO CANCER PAIN MANAGEMENT

A	**Ask** about pain regularly. **Assess** pain systematically.
B	**Believe** the patient and family in their reports of pain and what relieves it.
C	**Choose** pain control options appropriate for the patient, family and setting.
D	**Deliver** interventions in a timely, logical and coordinated fashion.
E	**Empower** patients and families. **Enable** patients to control their course to the extent possible.

Source: US Department of Health and Human Services pamphlet *Management of Cancer Pain in Adults*

which descriptive reports are numerous and controlled studies are lacking. However, the clinical use of opioids in cancer patients has forced a reconsideration of the basic pharmacologic observation. Tolerance is only problematic if the physician refuses to adminster larger than standard doses to patients in pain."

In the ECOG survey, physicians cited the inability to adequately assess pain as the greatest barrier to cancer pain management.

Issues which are known to lead patients to minimize pain include fear of addiction, narcotic side effects, loss of control, concern that worsening pain represents disease progression, ignorance (pain is inevitable with cancer), the desire not to distract the physician from treating the primary disease and the belief that pain medicines are reserved only for severe, end-stage pain.

Concern over regulatory review

A separate but equally important impediment to appropriate prescribing of narcotics by some physicians can be ascribed to concern about regulatory review. A prominent part of our national agenda is dealing with recreational drug use and the problems it causes. This appropriate concern has led various regulatory agencies to press issues such as triplicate prescription pads in an attempt to decrease drug diversion.

A recent survey of Wisconsin physicians found that, due to concerns about regulatory scrutiny, most respondents reduce drug dose and quantity and the numbers of refills or elect a drug in a lower schedule. Von Roenn and colleagues are among experts who have urged physicians who take care of cancer patients in pain to establish a dialogue with drug regulators and medical examining boards. They believe this will help assure that uncontrolled pain in cancer patients is not an unintended product of the war on drugs.

Cancer pain must also be considered as it relates to the suffering cancer patient's experience. Suffering may occur in the absence of physical pain related to psychological, social, financial and other factors. Relieving cancer pain is the most important starting point in the quest to alleviate cancer patients' suffering.

The tools and techniques to effectively manage the vast majority of patients with cancer pain are readily available and can be put into practice today. Given the current limitations in our ability to cure many advanced malignancies, frequently the most important and satisfying role the physician can play is to provide effective pain management. We as a profession must make the management of cancer pain a priority. IM

Uncontrolled pain should not be an unintended product of the war on drugs.

REFERENCES
For a copy of the reference list for this article, contact the authors or the editors of Iowa Medicine.

The Journal
of the Iowa Medical Society

Prostate cancer therapy: a recipe for confusion

● *William See, MD*

The patient with a newly diagnosed prostate carcinoma is forced to choose from a dizzying menu of treatment options which, by all appearances, seem to change on a daily basis. To make matters worse, optimal treatment selection is but one of multiple, equally controversial issues facing patients with, and physicians who manage, this enigmatic disease.

To attempt to exhaustively review the literature relevant to even a single one of these questions is beyond the scope of this article. Instead in the following paragraphs I hope to provide some insight into the genesis of these questions and a clincally relevant framework of information for managing the patient with, or suspected of having, prostate cancer.

Prostate cancer: a novel paradigm

Relative to other neoplasms the biology and natural history of prostate carcinoma is unique. Rather than discussing crude survival statistics in denominations of two or five years, prostate cancer specialists speak in terms of 10- or 15-year cause-specific survival rates. Two features of prostate cancer account for this disparate behavior. First, researchers estimate that tumor doubling time in prostate cancer ranges from 120 days to two years. Given that over 30 tumor divisions are required to kill the host, a prostate cancer may "co-exist" with its host for between 10 and 60 years. A recent study by Sakr et al showed this to be the case.[1] Autopsy studies from traumatic deaths of young men showed that 44% of prostates from men in their fourth decade (>30, <40) harbored either prostate intra-epithelial neoplasm or carcinoma. Twenty-five percent of black males and 30% of white males in the same age range had frank carcinoma.

The second idiosyncratic feature is that while prostate cancer may begin at an early point in a man's life, the disease has historically not been clinically detectable in most men until the seventh or eighth decade. At the time of diagnosis a significant percentage of men in this age group suffer serious co-morbid disease. The presence of co-morbid disease and a very slow tumor growth rate imply that the majority of men are destined to die with rather than of their prostate tumor.

If prostate cancer patients and their physicians agreed to therapy derived from the "logical" outcome of population-based statistics, our task would be simplified. One might easily conclude that carcinoma of the prostate is a disease with minimal impact on average life expectancy and does not warrant therapy. Unfortunately, patients do die of prostate cancer. The term "prostate cancer" continues to elicit a cancer-phobic response in those given this diagnosis. To the patient, it matters little that 10-year cause-specific survival in untreated men is between 80-90%. If you are unable to predict his outcome he is likely to request therapy with curative intent.

Can we make outcome predictions in individual patients? The extremes are easy. The 82-year-old with multiple medical problems, a Prostate Specific Antigen (PSA) level of 5 and a Gleason score 2 cancer found at trans-urethral prostatectomy is highly unlikely to die as a result of his tumor. At the other extreme, the 49-year-old with a PSA of 7.5 and a Gleason score of 8 found at biopsy is at serious risk for disease progression. Unfortunately, the vast majority of patients with carcinoma of the prostate fall into a "prognostic gray area" which precludes meaningful risk assessment.

Overtreatment of patients for whom prostate cancer poses little risk has become a

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for June 1994.

William See, MD
Dr. See is a surgical oncologist at the University of Iowa Hospitals and Clinics, Department of Urology, Iowa City.

Prostate cancer therapy: a recipe for confusion

continued

serious concern in the last five to 10 years. Widespread use of PSA as a "screening test" for prostate cancer has dramatically increased detection. However, death rates from prostate cancer remain relatively stable

These observations raise two important questions. Do cancers detected by PSA disproportionately represent the non-life threatening variety? Second, has so-called early detection and aggressive therapy with curative intent had any impact on disease outcome? A prominent urologist summarized the quandary of prostate cancer by saying, "Therapy may not be necessary in those whom it is possible, nor possible in those whom it is necessary."[2]

PSA: friend or foe?

Since the late 1980s, clinical use of PSA for detection of prostate carcinoma has increased dramatically. To say that this tumor marker has had a revolutionary impact on prostate cancer would border on understatement.

Unfortunately, in the novel paradigm of prostate cancer, PSA has proven to be a double-edged sword. While one edge promises to slay the dragon of prostate cancer, the other portends massive over-diagnosis, over-treatment and huge economic cost. Its proposed use as a screening test magnifies these concerns.

Perhaps no issue in the field of urology in recent years has so polarized the urologic community as PSA screening. In one camp the "true believers" decry the potential loss of life from not screening. In the other camp the "philistines" point out the lack of evidence that early detection has any impact on disease mortality. This controversy extends beyond the urologic community to national and international agencies. Both the American Urological Association and the American Cancer Society have come out in favor of prostate cancer screening.[3,4] At the same time consensus committees in the United States, France, Canada, and Sweden, as well as the International Union Against Cancer, have recommended against screening.[5]

Clearly, screening is a complex issue. While it might appear intuitively obvious that, as far as the bottom line is concerned, early detection will reduce mortality, lessons learned from the Mayo lung cancer screening study demonstrate this is not necessarily the case.[6]

Additionally, not screening has the potential to lose lives to prostate cancer, much as screening has the potential to impair both length and quality of life in large numbers of men. My personal opinion is that true screening for prostate cancer is premature.

Who needs treatment?

Given the protracted natural history of untreated prostate cancer, most urologists agree that patients require a minimum anticipated life expectancy of 10 years if they are to see benefit from therapy with curative intent. Several recent studies of "watchful waiting" as management for elderly men with prostate cancer support this approach.[7-9] In the meta-analysis by Chodak et al, only 9% of men died from their prostate cancer during a 10-year period.[10] During this same interval 30% of men died from co-morbid disease.

While this study has been criticized for including large numbers of men with other serious medical illnesses and relatively low grade tumor, it illustrates several important points. Untreated prostate cancer progresses very slowly and co-morbid disease often poses a far greater risk to the patient's life-expectancy than prostate cancer.

These studies have also provided insight into who is at risk for death from prostate cancer. High tumor grade and age at diagnosis of 61 or less were associated with a significantly increased risk of death from disease. The lower the tumor grade and the higher the patient age, the less likely the disease is to pose a life-threatening risk and the less likely the patient is to benefit from curative therapy. Conversely, the younger the patient and the higher the tumor grade, the more likely the patient is to die from their disease. These patients are most likely to benefit from curative therapies.

Therapy or waiting?

Radical retropubic prostatectomy, radical perineal prostatectomy, external beam radiotherapy, conformal radiotherapy, gold seed brachytherapy, iridium brachytherapy, and cryoprostatectomy are all in non-investigational clinical use in this country as curative therapies for prostate cancer. Add to this the

option of watchful waiting and the experimental modalities of hyperthermia and laser ablation, and you begin to get a picture of the lack of consensus surrounding optimal treatment.

If PSA has had any clear positive impact on the management of prostate cancer it is that it has prompted a critical reappraisal of treatment efficacy. Abundant data now suggests that, for both surgery and radiotherapy, a rise in PSA following therapy denotes disease recurrence. For patients undergoing treatment for disease which is clinically confined to the prostate, five-year PSA failure rates are between 61% and 87% following radical surgery and between 42% and 87% following external beam radiotherapy.[10-13]

These figures should not be interpreted as showing that treatment had no impact on survival, only that therapy frequently fails to render patients disease-free. Despite these seemingly discouraging numbers, radical prostatectomy and external beam radiotherapy must be considered the gold standards for treatment. Even less information is available on other approaches. This is particularly true for cryoprostatectomy which is being clinically utilized in a veritable vacuum of efficacy data.

In selecting between surgery and radiation therapy, the obvious first question is which is more effective for treating organ confined tumors? The short answer is "we don't know." Prospective randomized trials designed to address this question have failed due to poor accrual. Comparisons of outcomes based upon non-randomized clinical series are tenuous at best. The use of pathologic staging of both nodes and prostate in surgical series has the potential to bias results in favor of surgery. Until additional data becomes available, the conclusions of the 1988 consensus conference on prostate cancer remain valid: "Radical prostatectomy and radiation therapy are clearly effective forms of treatment in physicians' attempts to cure tumors limited to the prostate for appropriately selected patients. Comparisons across studies suggest comparable 10-year survival rates with either form of management."[14]

If therapeutic outcomes between radiation and surgery are largely equivalent, then selection of therapy in eligible patients becomes largely a matter of personal preference. Both modalities are associated with significant short- and long-term risks. To a large degree the increased short-term risks associated with surgery (bleeding, infection and anesthetic risks) are balanced by the increased incidence of long-term risks associated with radiation (radiation cystitis, bowel injury, secondary neoplasms). Interestingly, one-year impotence rates appear to be roughly equivalent.

The larger question is whether any therapy alters the natural course of this disease. The excellent actuarial survival curves which follow treatment with any modality reflect the fact that the majority of patients would have done well in the absence of any treatment. Fortunately, a trial is planned which may answer this crucial question. The Prostate Intervention Versus Observation Trial (PIVOT), jointly sponsored by the NCI and the Department of Veterans Affairs, is a randomized prospective trial comparing observation (watchful waiting with hormonal therapy for progression) to radical prostatectomy. This trial will open in late 1994 or early 1995 and promises to address the pivotal issue in prostate cancer.

Practical considerations

For non-urologists the serum PSA test poses more problems than any other issue. I limit use of PSA to three groups of patients:

(1) those who express a concern regarding carcinoma of the prostate, or in whom I suspect on the basis of the digital rectal exam of having prostate cancer, who would be candidates for therapy with curative intent (absolutely < age 75, most <70 unless extremely healthy); (2) patients in whom I suspect metastatic carcinoma of the prostate as the etiology of their symptoms; (3) patients at high risk for developing and succumbing to prostate carcinoma (blacks, positive family history in a first-degree male relative).

For patients who request a serum PSA for screening purposes, I provide informed consent as to the implications of an elevated PSA, the need for additional tests to identify the causes of PSA elevations, the indolent nature of prostate carcinoma in the majority of patients and the relative paucity of data regarding treatment efficacy. Too often, patients naively obtain a serum PSA and later realize the chain of events which almost

Prostate cancer therapy: a recipe for confusion

continued

reflexively occur in the face of an elevated value and frequently culminate in interventions with serious morbidity.

For patients with a histologic diagnosis of prostate cancer it is important early on to define the objectives of therapy. Curative therapy should be limited to those with a minimum anticipated survival of 10 years. A common misconception occurs in the patient too ill or frail to undergo surgery for their cancer. Very few of these patients will survive 10 years and as such will not benefit from any curative intervention. Rationalizing curative radiotherapy in these patients on the basis of "less acute morbidity" with radiation represent flawed logic. While radiotherapy may be better tolerated, in the absence of benefit any morbidity is unacceptable. Often the most difficult aspect of managing these patients is overcoming the desire, frequently prompted by the patient, to do something.

A final comment relates to palliative treatments delivered to reduce symptoms. So-called "prophylactic palliation" makes very little sense. There is no literature to support the use of curative modalities (both surgery and radiation) to prevent subsequent local complications in patients who are asymptomatic, but incurable. The same is true for the timing of intervention with hormonal therapy in patients with metastatic disease. In the absence of data which suggests a survival advantage to early vs. delayed hormonal therapy, early intervention in asymptomatic patients simply subjects them to increased cost and prolonged morbidity of therapy.

Tomorrow's menu

While many questions remain unanswered, I am optimistic that the future holds improvements in both care and outcome for patients with this illness. After decades of seeming neglect, increased federal funds have been appropriated for prostate cancer research. Patients with this disease are becoming increasingly interested in and outspoken regarding their illness. Clinical studies such as the PIVOT trial promise answers to important questions, while others are pursuing approaches to prevent tumor development (Prostate Cancer Prevention Trial). Until such time as answers are available, clinicians must exercise caution in both who we treat and how we treat them.

References

References noted in this article are available from the author or the editors of *Iowa Medicine.* IM

Introduction to Telemedicine Workshop

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The Iowa Legislature has authorized use of the fiber optic network by physicians and hospitals. Are you prepared to take advantage of this new technology? This workshop will introduce you to telemedicine, including an explanation of what it is and examples of how it is used. You will get a head start in understanding what telemedicine is all about and how to initiate a project in your community. Speakers will include Dr. Michael Kienzle of the University of Iowa and other Iowa physicians who are on the Governor's Telemedicine Advisory Council. There will also be a tour of the Iowa Communications Network hub site at the Iowa National Guard Armory in Johnston.

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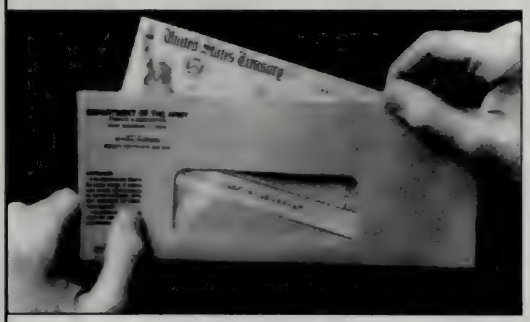
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Benign prostatic hypertrophy



MARION ALBERTS, MD

The year was 1941. The place was Lincoln (Nebraska) General Hospital. The scenario involved me as a second year premedical student working for board and room. Several of us premed students were hired to serve as orderlies; a great job in those days because we had clean living quarters, good food and lots of student nurses available to date. (That's where I met my future "one and only" wife.)

As orderlies, our primary tasks were to do urinary catheterizations of male patients and remove or trim orthopedic plaster casts. LGH had very active urology and orthopedic services. Little did I realize then that more than 50 years later I would be writing editorial comments about benign prostatic hypertrophy (BPH).

As an aside, I might comment that I eventually graduated from orderly service to switchboard operator and evening admitting clerk . . . both much more to my liking.

At that time, being very innocent about things medical, I did not realize so many "old men" had problems with voiding. To a young student, it was ghastly. What was wrong with them? The wages of sin? Self-abuse? A price to pay for aging? All terrible thoughts in the mind of a young student not yet aware of the simple facts of life.

To a young student, it was ghastly. What was wrong with them? The wages of sin?

More than half of American men are affected by BPH by age 60. A conservative estimate based on US Census projections suggests that in 1994, at least 4.7 million men in their 60s are likely to be affected by BPH. As many as 90% of men by age 85 will have microscopic evidence of BPH; an estimated one in four men by age 80 will require treatment for BPH symptoms.

The Agency for Health Care and Policy of the US Department of Health and Human Services recently made available excellent reference materials about BPH. The materials include a 225-page clinical practice guideline, a quick reference guide for clinicians and a patient guide.

Based on extensive study by an interdisciplinary, non-federal panel of eminent health care professionals, the materials contain much valuable information.

The highlights of patient management include: signs and symptoms, complications, diagnostic evaluation (including enumeration of tests not recommended in routine cases) and treatment. An excellent decision diagram of management concisely reviews the scope of the complexity of BPH management. Finally, an assessment of treatment outcome is presented.

All physicians charged with the health care of adult males should obtain these materials. They are free. Write to: BPH Guidelines, PO Box 8547, Silver Spring, Maryland 20907. Better yet, call 1-800-358-9295.

Any physician over 60 years old would find these materials most informative. I give them a five-star rating. IM

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The four-day (July 28-31) Bix Arts Fest - which features musicians, outdoor merchants, crafts, art, and plenty of food - is the backdrop for a weekend of activities.

Now in its fourth year, Cardiology at the Bix, sponsored by St. Luke's Regional Heart Center has featured internationally acclaimed speakers, as well as attendees from all over the country. Held at the beautiful, Jumer's Castle Lodge in Bettendorf, it draws internationally acclaimed physicians.

Attendees can also enjoy the Bix Beiderbecke Memorial Jazz Festival, which features top-notch bands from around the world and honors Davenport native son and jazz great Bix Beiderbecke.

More than 18,000 runners are expected for what Runner's World calls "the road race with the most community spirit." Scheduled for July 30, the Bix 7 is the eighth largest road race in the United States.

Faculty

THOMAS SHIMSHAK, M.D., Clinical Associate Professor of Medicine, University of Missouri, Kansas City, Missouri.

JONATHAN LANGBERG, M.D., Professor of Medicine, Director Electrophysiology Laboratory, Emory University Hospital, Atlanta Georgia.

NORA F. GOLDSCHLAGER, M.D., Professor of Clinical Medicine, UCSF, San Francisco, California.

LINDA JEAN CROUSE, M.D., F.A.C.C., Clinical Assistant Professor of Medicine, University of Missouri School of Medicine, Director of Echocardiac Lab and Director of Women's Cardiac Center, Mid-America Heart Institute, St. Luke's Hospital, Kansas City, Missouri.

ALLAN ROSS, M.D., Professor of Medicine and Director of Cardiac Services, George Washington University, Washington, DC.

STUART FINE, M.D., Clinical Instructor, University of Illinois College of Medicine, Chicago, Illinois.

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Who attends CME courses, anyway?

Physicians who register at CME courses usually find themselves among familiar faces, especially when a course is held within a community or is oriented to a particular medical specialty. Just as common, however, are the unfamiliar faces. Many CME courses offered at institutions such as the University of Iowa attract statewide participants. Since Iowa has over 4,000 practicing physicians, the likelihood of unfamiliarity at such courses is high.

The Office of Continuing Medical Education at the University has developed a means to identify the faces of physician registrants for courses which it sponsors. This identification is of course not literal, but in terms of the specialty, practice arrangement, age, county of residence, size of community and other characteristics of the physician registrants. This new capacity derives from the computer linkage of CME registrations to the Iowa Physician Information System, a current demographic profile of physicians in practice in Iowa. The system is maintained by the UI's Office of Community-Based Programs.

Physicians register for CME courses in proportion to their specialty numbers in Iowa.

Registration information from the 1992-93 program year (the first year that the linkage was operative) has been analyzed with some interesting findings:

- Physicians are registering for CME courses in proportion to their specialty numbers in Iowa. The primary care specialties of family practice, internal medicine and pediatrics have the largest participation in numbers.
- Physician registrants represent all types of practice arrangements; physicians in 3-6 person specialty groups and solo practitioners are the largest groups of registrants.
- Physicians between 30 and 49 years of age are the most frequent registrant groups by age, but sizable numbers of physicians past the usual age of retirement (65 years) maintain their CME involvement.
- The most frequent attendees by county practice in communities with populations of 50,000 to 74,999 but physicians from more rural counties are also well-represented.



Richard Nelson, MD

Why is this information important? The profile of CME registrants will be especially useful for recurring courses that target select physician audiences. Knowledge of past registration demographics will assist course directors seeking to identify their audiences. Are physicians in the relevant specialties participating? Are physicians in certain regions of the state, or at career stages being reached? Can physicians in solo or small practice arrangements attend? Such information can help the course director in determining content, marketing and even the location of the course.

Further, in reviewing the topical matter covered in courses over time, the College can initiate new CME activities that address emerging medical care issues not otherwise scheduled.

Knowing who is coming tells us where we should be going. IM

Classified Advertising

Emergency Medicine Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

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Explore Minnesota and Primary Care—With North Memorial Medical Center primary care network. Openings are available for: family practice, internal medicine and OB/GYN physicians and physician assistants. These opportunities offer stability without sacrificing autonomy. Single and multispecialty groups in urban, suburban and semi-rural settings. Teaching opportunities with North/University of Minnesota residency program. Competitive compensation structures and flexible schedules with independent or hospital owned group practices. Immediate access to Minneapolis/St. Paul attractions. Central to Minnesota's abundant lakes country. If you are BC/BE send your CV or call in confidence to North Medical Programs, North Memorial Medical Center, 3300 Oakdale Avenue North, Robbinsdale, Minnesota 55422-2900. Nationwide and Canada 1-800/275-4790.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

General Surgeon—Wanted to join primary care group of 8 established physicians with a captive on-site referral base. This position offers outstanding professional, financial and lifestyle opportunities with outstanding school system. Please call Linda Cohrt, Family Medical Center (515/673-6762) or mail CV to 1225 C Avenue East, Oskaloosa, Iowa 52577; fax 515/672-2258.

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Family Practice, Carroll, Iowa—Outstanding professional opportunities for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197, or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

General Surgeon BE/BC—The Department of Surgery at the Mayo Clinic in conjunction with the Decorah Clinic is seeking a broad-based general surgeon to join the Mayo Regional Facility in Decorah, Iowa, 70 miles south of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 9-person, Mayo-affiliated medical clinic in this town of about 8,100 with a 60-bed hospital and a county population of 26,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise and excellent salary and benefits. Inquiries to Michael G. Sarr, MD, Department of Surgery, Mayo Clinic, Rochester, Minnesota 55905. Mayo Foundation is an affirmative action and equal opportunity educator and employer.

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Opportunities Available—Family practice, general surgeon, emergency medicine, internal medicine, locums, ob/gyn, occupational medicine, pediatrics, urgent care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, Minnesota 55430; 1-800/248-4921 or 612/574-7627.

Emergency Medicine—McFarland Clinic, P.C., is actively recruiting a BE/BC family medicine physician. Physician will participate in rotation of 24-hour on-site emergency coverage at Mary Greeley Medical Center, a 200-bed hospital located in Ames, Iowa. Emergency Department, rated Level II JCAHO accredited, is staffed by family practice physicians where approximately 15,000 patients are seen annually. Patient mix is midwest suburban with a low incidence of major trauma and drug-related problems. As a multispecialty clinic of 96 physicians representing over 25 medical and surgical specialties, McFarland Clinic physicians provide 1st and 2nd medical back-up for ER physicians as well as specialty physicians on-call for needed consultations. McFarland Clinic, P.C. offers excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Equipment for Sale—IMEX Mascot D201, Vascular Doppler, 2 scopes, never been used. $795.00 brand new, asking $600. Contact Dr. Donald A. MacKenzie, 515/967-3996.

Emergency Medicine, Council Bluffs, Iowa—Opening available for qualified physician to join group of emergency physicians. Training and/or certification in primary care specialty or emergency medicine. Flexible scheduling. Newly remodeled emergency department. Enjoy a rural and urban atmosphere. Write Bluffs Emergency Care Services, P.C., 933 East Pierce Street, Council Bluffs, Iowa 51503; 712/328-6111.

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Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

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Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Iowa State University, Student Health Physician—With training/experience in primary care sports medicine to join 9 physicians providing primary care to 24,000 students. Duties include supervision of sports medicine services for the Athletic Department and routine medical care in a campus-based outpatient clinic. BC/BE in primary care, Iowa license or eligible. Salary and benefits competitive. 12-month position. Target starting date mid-August 1994. Deadline for application June 30, 1994 or until filled. Send CV or inquiries to Robert K. Patterson, MD, Director, Student Health Center, Iowa State University, Ames, Iowa 50011; 515/294-5802.

(Continued next page)

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Iowa State University, Student Health Physician—BC/BE in primary care, to join 9 other physicians in ambulatory care service to 24,000 students. Duties include office gynecology and general medicine in a campus-based outpatient clinic. Experience in sports medicine a plus. Iowa licensed or eligible. Salary and benefits competitive. 12-month position. Target starting date mid-August 1994. Deadline for application June 30, 1994 or until filled. Send CV or inquiries to Robert K. Patterson, MD, Director, Student Health Center, Iowa State University, Ames, Iowa 50011; 515/294-5802.

Chariton, Iowa—Full range FP practice, including OB. Also offers liberal call of 1 in 5, modern office facilities with room to expand, outstanding income guarantee plus benefits. State-of-the-art hospital. This progressive community is 1 hour from Des Moines. For more information contact Beckie Jacobs, 800/678-7858 or fax CV to 314/726-0026.

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Family Practice, Fairfield, Iowa—Over $100,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

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Here's to your Health

The Iowa Medical Society has published 3 patient inserts in recent months. In addition to the insert in the center of this magazine on prostate cancer, 2 other patient inserts are also available: low back pain and menopause and estrogen therapy. Original inserts may be purchased for 15 cents each plus postage. A bill will accompany your insert order.

Call Jane Nieland or Bev Corron at 800/747-3070 or 223-1401 to order inserts or send the completed form below to: *Iowa Medicine,* 1001 Grand Avenue, West Des Moines, IA 50265.

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Address _____

City _____ State ____ Zip _____

Insert ordered:	Number of inserts
_____ Low back pain	_____
_____ Menopause & estrogen therapy	_____
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West Des Moines 50265
515/223-8622

Pediatric and Adult Allergy, PC
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James D. Bunker, MD, FAAD
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Fort Dodge 50501
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Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
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24 Hours 515/224-1777

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515/573-4141

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Waterloo 50702
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515/283-5760
Neurological Surgery

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S. Randy Winston, MD
Douglas R. Koontz, MD
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Des Moines 50312; 515/283-2217

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Cedar Rapids 52402
319/363-4622
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Earl R. Elowsky, MD
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Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
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Iowa City 52245
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Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Timothy F. Moran, Jr., MD
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Sioux City 51104
712/252-4333
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1953 1st Avenue, Cedar Rapids 52402
1400 7th Avenue, Marion 52302
1-800/I SEE YOU

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Cedar Falls 50613
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Cedar Rapids 52403
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Richard B. Merrick, MD
3901 Ingersoll
Des Moines 50312
515/274-9135

Dubuque Otolaryngology Service, PC
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James W. White, MD
Craig C. Herther, MD
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Dubuque 52001
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(Continued next page)

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Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
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Urology

Fort Dodge Medical Center, PC
Leland M. Coffman, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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When patients are victims

Broken noses, fractured jaws, ruptured ear drums, facial bruises, torn out earrings. Physicians should take special note of these signs of trauma that could also be signs of violence. The patient's explanation of running into a door, falling down the steps, slipping in the bathtub, rolling the snowmobile or children pulling out the earrings may not be the way the injury really happened.

A little closer questioning by the physician could bring enlightenment.

In articles in *JAMA* and *Redbook Magazine,* Dr. Gail Bundow, a former battered wife, said she was treated for beatings repeatedly in the emergency room but was never asked by a physician what had happened.

"When doctors suspect abuse, many don't want to get involved because it makes them uncomfortable," she commented. "They might play golf with the woman's husband. It's easier just to give the woman medical care. It's tragic because doctors are in a unique position to help."

Violence is a special project of the IMS Alliance this year. Together with other interested organizations, the IMSA is participating in the "Zero Tolerance for Violence" project which featured a series of town meetings and a day-long symposium in late May at the Des Moines Convention Center.

In addition, the IMS Board of Trustees has decided to appoint a committee which will study ways to educate physicians and patients on the effects of violence.

Iowa has about 30 programs dealing with family violence in larger population centers. Crisis lines operate 24 hours a day. Brochures are available explaining domestic violence. However, much has yet to be done in individual counseling, group support, education programs for children and volunteer hours taking care of shelters and answering hotline calls.

According to a recent article in *AM News*, respondents to a survey saw educational material on family violence 35% of the time in the doctor's office. Perhaps physicians could do a better job of educating our patients by having such materials available.

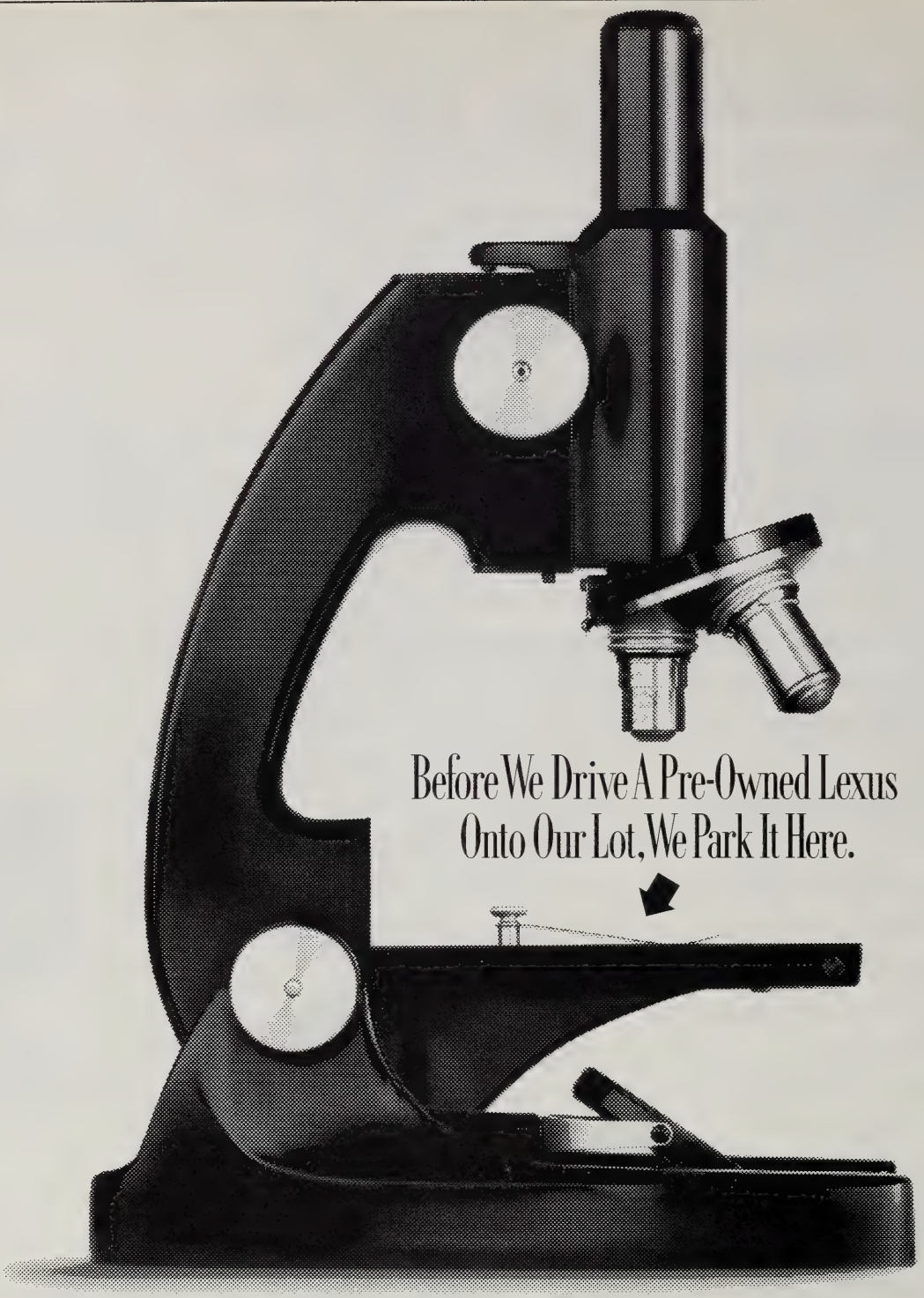
In rural areas of Iowa, family violence presents special problems for patients and physicians. In smaller communities, there is a special fear of embarrassment because everyone knows everyone else. It may be much more difficult for a physician to intervene if he or she is well-acquainted with all members of a family.

The patient's explanation may not be the way the injury actually happened.

Iowa law is very clear in requiring two hours of training every five years for physicians who provide primary care to children and dependent adults. However, in the case of domestic abuse, the victims have to be encouraged to seek help. It means little to have services available if those services aren't actually used. Physicians need to seize every opportunity to intervene and not just pass the problem to the primary care doctor or to the specialist. We are all in a position to help. IM



James White, MD



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IMS Update

Please return verification letter

July 15 is the deadline for returning your IMS member verification letter. The letter, which verifies member information for IMS records and the IMS Membership Directory, was sent to all physicians in early June.

In response to a directive from the IMS Strategic Planning Committee, the letter asks for additional data such as clinic names, physician social security numbers, home addresses, spouses' names, residencies, office fax numbers. This information will allow IMS to be more responsive to member needs and target information pertinent to specific types of practices.

It is important that you return your letter to ensure the correct information about your practice appears in this year's directory. The 1994-95 IMS Membership Directory will be distributed in October. If you misplaced your letter or did not receive one, call Sheryal Westbrook or Sandy Nelson at the IMS, 515/223-1401 or 800/747-3070 to verify your information.

BME appointments

Teresa Mock, MD, a Mason City family physician, has been appointed by Governor Branstad to the Iowa State Board of Medical Examiners. James Collins, MD, a Waterloo pathologist, has been elected BME chairman.

House of Delegates participation

The IMS Board of Trustees will study ways to increase participation in the annual House of Delegates meeting. At this year's April 16-17 House of Delegates, 51 counties had no representation and 17 counties did not have a full delegation in attendance.

The Board will also consider ways of modifying the IMS governing structure to assure more participation by groups of physicians at an August strategic planning meeting.

The opinions of the IMS Judicial Council, delegates and alternate delegates to the AMA and the House speaker and vice speaker are also being sought. In addition, a survey of all IMS delegates is being conducted.

Any IMS member physician who has an opinion about participation in the House of Delegates or alternative governing structure is urged to call or write Dean Gillaspey at IMS headquarters, 515/223-1401 or 800/747-3070.

IMS committees restructured

In keeping with a bylaws change approved by the IMS House of Delegates, Iowa Medical Society committees have been restructured to make them more efficient. Rather than retain a large number of standing committees, there will be four standing committees: the Committee on Legislation, the Committee on Medical Education, the Committee on Medical Service and the Committee on Nominations. Fifteen special committees are also being retained.

Under the new structure, other committees will be appointed by the board to deal with specific issues. These committees will be dissolved when their charges have been fulfilled.

Physicians being asked to serve on committees were notified last month. Please return your response card if you have not already done so or call Becky Bales at IMS headquarters, 515/223-1401 or 800/747-3070.

Specialty Society Update

The Iowa Association of County Medical Examiners will hold an education/business meeting Friday, October 28 at the Starlite Best Western in Ames.

The American College of Cardiology, Iowa Chapter, will hold a membership meeting Friday, July 29 at the Eagle Ridge in Galena, Illinois.

The Iowa Medical Group Management Association Information/Communications Committee will meet Wednesday, July 13 at 11 a.m. at the IMS.

The Iowa Medical Group Management Association Insurance/Reimbursement Committee will meet Wednesday, July 20 at 10 a.m. at the IMS.

AT A GLANCE

In the coming months, the IMS Board of Trustees plans to hold special meetings with groups including the Iowa Association of Business and Industry and the Farm Bureau Federation, the Department of Public Health, presidents of the 16 largest county medical societies and representatives of specialty societies.

Special elections are being held in IMS Councilor Districts 2 and 9 to replace Siroos Shirazi, MD, who was elected to the IMS Board of Trustees and Don Orelup, MD, who resigned. Election results will be reported in the August Iowa Medicine.

A representative of IPTV-Channel 11 says the documentary "When Doctors Get Cancer" *will air again on that station. The documentary, which was shown in May, received many positive comments from physicians. Watch upcoming issues of* Iowa Medicine *for the date and time of the next airing.*

IMS Update

continued

The ethics of rationing

The August *Iowa Medicine* will contain an article on Iowa criteria for liver transplantation in alcoholic patients. Also included will be a discussion on the ethics of rationing care according to lifestyle choices.

IMS committee on domestic violence

The IMS Board of Trustees will appoint a committee to develop specific recommendations on projects to educate physicians and/or the public regarding the effects of domestic/family violence. The Iowa Medical Society Alliance will be represented on the committee.

Barbara Bell, IMSA president, is representing the Alliance on the "Zero Tolerance for Violence" coalition which has held town meetings around central Iowa. The group also held a one-day symposium in Des Moines.

Iowa was one of only five states with an increase in (Alliance) membership.

New AMA mission statement

The AMA Board of Trustees has approved a new mission statement.

"We are the voice of the American medical profession.

"We are the partnership of physicians and their professional associations dedicated to promoting the art and science of medicine and the betterment of the public health.

"We serve physicians and their patients by establishing and promoting ethical, educational and clinical standards for the medical profession and by advocating for the highest principle of all — the integrity of the physician/patient relationship."

IMS, IAFP officers meet

Dr. James White, IMS president, and IMS board members William McMillan, MD and Joseph Hall, MD met recently with officers of the Iowa Academy of Family Physicians. On the agenda was strategies the two organizations will employ to assist their members with managed care trends.

1994 Family Practice Fair

The 1994 Iowa Family Practice Opportunities Fair will be held Saturday, August 27 at the Savery Hotel and Des Moines Convention Center. The event is cosponsored by the Iowa Medical Society and the Iowa Academy of Family Physicians. Last year, 61 community groups and 61 residents looking for practice opportunities attended the fair. For more information on this year's fair, call 319/335-8618.

Focus on IMS Alliance

Now 1,240 members strong, the IMS Alliance is alive and well. At the close of our fiscal year in May, Iowa was one of only five states with an increase in membership.

Also, the IMSA contributed over $20,000 to AMA-ERF — an increase of 56% over last year. The AMAA contribution was $2.3 million. These contributions are the result of our fund-raising efforts and provide a legacy from one generation of medical professionals to the next. This is a real investment in the health of generations to come.

Our legislative efforts did not stop with the adjournment of the Iowa Legislature. On June 2, our legislative chair conducted a mini-internship orientation program for county coordinators involved in this project. As of press time, we have 27 counties represented to serve 108 legislators. The matching process for physicians and legislators is almost complete. Mini-internships will begin by early fall.

Our primary focus this year is community violence. In May, we joined with a coalition of business, governmental and health-related organizations to produce a symposium on violence at the Convention Center in Des Moines. The symposium, which focused on solutions, drew nearly 700 people. We look forward to combining forces with the IMS this year in a continuing effort to focus on this most serious health issue of the 1990s.

Contributed by Barbara Bell, IMSA president

Iowa Health Council to meet

The Iowa Health Council will hold its annual education conference Wednesday, July 20 at IMS headquarters. The group is comprised of CEOs and officers of 13 health-related organizations. The meeting will be an opportunity for discussion of important health care issues and legislative concerns.

Iowa physician elected to AMA post

Dr. Donald Young, a Solon radiologist, has been elected to the American Medical Association Council on Scientific Affairs. Dr. Young was elected June 15 during the AMA's Annual House of Delegates meeting in Chicago. Dr. Young has been an AMA delegate since 1982. IM

Health System Reform

New IMS project will help physicians plan for the future

Do you have a plan for the future of your practice?

The Iowa Medical Society is beginning a new educational and consulting services initiative called **"Futures . . . strategies for tomorrow's practice".** The goal of the program is to help Iowa physicians plan for changes likely to arise as a result of health system reform.

FUTURES
Strategies for tomorrow's practice

There will be two major components to the program. The first will be efforts to educate physicians regarding health system reform, managed care, physician integration strategies, physician-hospital integration options, contracting and negotiating and other issues which can help physicians prepare for changes in the health care environment.

The second component will involve development of a directory of consulting services that can be coordinated through IMS.

The IMS Futures program will involve written educational materials, several regional educational meetings in September and a statewide conference for all IMS members and specialty society presidents in late October. In the coming months, IMS representatives will give presentations at county society meetings by invitation.

Watch the August *Iowa Medicine* for more details on the regional and statewide conferences and other educational efforts.

AMA managed care guide

The AMA has available the "Physician's Guide to Selecting and Working with a Managed Care Consultant." The guide discusses when to hire a consultant, what it will cost and other issues.

The guide is free to AMA members by calling AMA customer service, 800/621-8335, order number OP 631193MD.

Antitrust initiative sparks controversy

The AMA-backed antitrust reform legislation sponsored by Rep. Bill Archer of Texas had 106 cosponsors as of press time.

However, consumer advocates, insurance companies and the American Association of Retired Persons (AARP) are fighting antitrust relief for physicians. The groups sent a letter to Congress warning that such relief is "a threat to consumer welfare". Several big business groups and an array of non-physician health providers also signed the letter.

Meanwhile, the AMA and 100 other medical groups sent a letter to every member of Congress saying the antitrust bill would "clear away the insurance companies' smokescreen and refute scurrilous arguments" regarding the AMA's antitrust law.

AMA Patient Protection Act

The American Medical Association has unveiled a new legislative proposal, the Patient Protection Act, to guarantee that patients and their physicians — not insurance companies — make decisions about medical care.

"Patients should no longer be subject to the 'health insurance lottery', " commented Ted Lewers, MD, an AMA trustee who visited Des Moines recently to promote the AMA Patient Protection Act to local media. "They should never be surprised to discover their insurance doesn't cover their health care needs, their regular doctor can no longer treat them or they

continued

AT A GLANCE

A USA Today *cover story warned health system reform is leading to a two-tier system where the affluent choose any care they want and everybody else is in a managed care plan.*

The Kiplinger Newsletter *speculates a broad-based tax to extend health care coverage is unlikely from this Congress because lawmakers believe most voters are satisfied with their coverage and don't want their taxes raised.*

The President's call for restraints on medical expenditures is getting a new push from Democrats, who see no way to pay for universal coverage without it. According to an AP editorial, the President's proposal for spending caps hasn't generated as much controversy as his employer mandate proposal. However, most Republicans oppose caps.

Health System Reform

continued

won't be allowed access to the specialty care they need."

The AMA ran a full-page ad in several large newspapers explaining the proposal. Introduction of the proposal sparked an unfavorable editorial in the *New York Times*, which labeled it "same old AMA".

The AMA then responded with a letter to the editor, debating the *Times'* contention that health plans guarantee the best care possible. "Doctors guarantee care, " read the letter. "Insurance companies determine quality with a calculator."

"Doctors guarantee care. Insurance companies determine quality with a calculator."

The Patient Protection Act, which has been introduced in Congress, would entitle patients to:

- A list of covered services — exactly what the plan pays for.
- A list of exclusions — what patients need to pay for themselves.
- Clear instructions on whom to call before a physician can treat them.
- Survey information on how other patients feel about the health plan.
- A choice of three plan options (HMO or PPO, traditional insurance or a benefit payment schedule).
- Access to a point-of-service plan — the opportunity to pay extra to see a doctor outside the plan.

To allow physicians to give patients the care they need, the plan would be required to give physicians a voice in medical policy-making. In addition, no physician could be removed from a plan for giving patients the care they need. Practicing physicians would have an essential role in developing criteria to ensure quality care and plans would be required to disclose to physicians exactly who is reviewing their work.

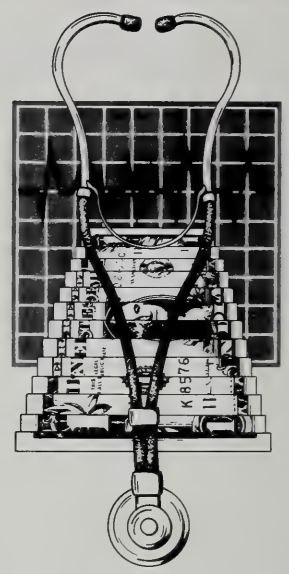
During his visit to Iowa, Dr. Lewers was interviewed by WHO Radio, the *Business Record* and the *Des Moines Register* editorial staff. IM

Worth Repeating

"The push for health system reform is sorely lacking the leadership to achieve the 'shared sacrifice' necessary for a lasting solution."

George Lundberg, MD, *JAMA* editor

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Des Moines, Iowa



Bruce McGehe
Des Moines, Iowa

Legislative Affairs

How our *Iowa Representatives* voted . . .

Bills *IMS position in green*	Arnould	Baker	Beaman	Beatty	Bell	Bernau	Black	Blodgett	Boddicker	Brammer	Brand	Branstad	Brauns	Brunkhorst	Burke	Carpenter	Cataldo	Churchill	Cohoon	Connors	Corbett	Daggett	Dickinson	Dinkla	Doderer
SF 287 — Psychologists' hospital privileges N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
SF 2089 — Conference report, state fiber optic network Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	A	Y	Y	N	Y	Y
SF 2053 — Nurse anesthetist, nurse practitioner prescribing N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SF 2222 — Allow debate of Senate health care bill in House (Neuhauser motion) N	Y	Y	N	Y	Y	Y	Y	N	N	Y	Y	N	N	N	Y	N	Y	N	Y	A	N	N	Y	N	Y
HF 2376 — H-5507 Tobacco Free Coalition proposal (Brammer) Y	Y	N	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	Y	N	Y	Y	A	N	Y	A	Y	Y
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Bills *IMS position in green*	Drake	Dvorsky	Eddie	Ertl	Fallon	Fogarty	Garman	Gill	Gipp	Greig	Greiner	Gries	Grubbs	Grundberg	Hahn	Halvorson, Rod N.	Halvorson, Roger A.	Hammond	Hansen, Steven	Hanson, Darrell	Hanson, Donald	Harper	Haverland	Henderson	Hester
SF 287 — Psychologists' hospital privileges N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
SF 2089 — Conference report, state fiber optic network Y	Y	*	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y
SF 2053 — Nurse anesthetist, nurse practitioner prescribing N	Y	*	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y
SF 2222 — Allow debate of Senate health care bill in House (Neuhauser motion) N	N	*	N	N	Y	Y	N	Y	N	N	N	N	N	N	N	Y	N	Y	Y	N	N	Y	Y	Y	N
HF 2376 — H-5507 Tobacco Free Coalition proposal (Brammer) Y	N	*	N	N	Y	N	N	Y	N	N	N	N	N	Y	N	Y	N	Y	N	Y	Y	Y	Y	Y	N
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

KEY TO VOTING RECORDS OF IOWA REPRESENTATIVES AND SENATORS

Y Voted YES on bill or amendment
N Voted NO on bill or amendment
A Absent or not voting
P Voted present (possible conflict of interest)
* Not serving in that chamber at the time of the vote (several special elections occurred in 1993 and 1994)

Bills

IMS position in green

	Holveck	Houser	Hurley	Iverson	Jochum	Kistler	Klemme	Koenigs	Krelman	Larkin	Larson	Lundby	Martin	May	McCoy	McKinney	McNeal	Mertz	Metcalf	Meyer	Millage	Miller	Moreland	Mundie	Murphy	Myers
SF 287 — Psychologists' hospital privileges N	Y	Y	Y	N	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	*
SF 2089 — Conference report, state fiber optic network Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
SF 2053 — Nurse anesthetist, nurse practitioner prescribing N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	N	N	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y
SF 2222 — Allow debate of Senate health care bill in House (Neuhauser motion) N	Y	N	N	N	Y	N	N	Y	Y	Y	N	N	N	Y	Y	Y	N	Y	N	N	N	N	Y	Y	Y	Y
HF 2376 — H-5507 Tobacco Free Coalition proposal (Brammer) Y	Y	N	N	N	Y	Y	Y	Y	N	Y	N	N	Y	Y	N	Y	Y	N	N	N	N	Y	N	Y	Y	Y
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	*

Bills

IMS position in green

	Nelson	Neuhauser	O'Brien	Ollie	Osterberg	Petersen	Plasier	Rafferty	Rants	Renaud	Renken	Royer	Running	Schrader	Shoultz	Siegrist	Spenner	Tyrrell	Van Maanen	Vande Hoef	Weidman	Weigel	Welter	Wise	Witt
SF 287 — Psychologists' hospital privileges N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	A	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y	Y
SF 2089 — Conference report, state fiber optic network Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SF 2053 — Nurse anesthetist, nurse practitioner prescribing N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y
SF 2222 — Allow debate of Senate health care bill in House (Neuhauser motion) N	Y	Y	Y	Y	Y	Y	N	N	N	Y	N	N	Y	Y	Y	N	N	N	N	N	N	Y	N	Y	Y
HF 2376 — H-5507 Tobacco Free Coalition proposal (Brammer) Y	N	Y	Y	Y	Y	N	Y	Y	N	N	N	N	N	Y	Y	N	Y	N	N	N	N	Y	N	Y	Y
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	A	Y	Y	Y	Y	Y	A	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Legislative Affairs

continued

How our *Iowa Senators* voted . . .

Bills *IMS position in green*	Banks	Bartz	Bennett	Black	Boettger	Boswell	Buhr	Connolly	Dellinger	Dieleman	Drake	Fink	Fraise	Freeman	Gettings	Glannetto	Gronstal	Hedge	Hester	Horn	Husak	Jensen	Judge	Kersten	Kibbie	Dvorsky
SF 287 — Psychologists' hospital privileges N	N	Y	N	N	N	Y	N	Y	Y	Y	N	Y	Y	*	Y	Y	N	A	Y	Y	Y	Y	Y	N	Y	*
SF 2089, S-5396A — Physician-hospital access to state fiber optic network (Kramer et al) Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SF 2053, S 505 — Limit CRNA, NP prescribing to rural areas Y	N	N	N	Y	Y	N	N	N	N	N	Y	N	N	Y	N	Y	N	N	Y	N	N	Y	N	A	N	N
SF 2222 — Senate health care bill, mandated direct access to nonphysicians N	N	N	N	Y	N	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y	N	N	Y	Y	N	Y	N	Y	Y
SF 2222, S-5156 — Physician self-referral (Riordan, Lloyd-Jones) N	N	N	N	Y	N	Y	Y	Y	N	Y	N	N	Y	N	Y	N	Y	N	N	Y	Y	N	Y	N	Y	Y
HF 2376, S-5463 — Removes Tobacco Free Coalition language (Buhr-Appropriations Committee) N	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	N	N	Y	Y	Y
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	*	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	*

Bills *IMS position in green*	Kramer	Lind	Lloyd-Jones	Maddox	McKean	McLaren	Murphy	Palmer	Pate	Priebe	Redfern	Rensink	Rife	Riordan	Rittmer	Rosenberg	Sorensen	Sturgeon	Szymoniak	Taylor	Tinsman	Vam	Vilsack	Welsh	Zieman
SF 287 — Psychologists' hospital privileges N	P	N	Y	N	Y	N	Y	Y	Y	Y	*	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
SF 2089, S-5396A — Physician-hospital access to state fiber optic network (Kramer et al) Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y	Y	Y	*	Y	Y	Y	Y
SF 2053, S 505 — Limit CRNA, PA prescribing to rural areas Y	Y	Y	N	Y	N	Y	N	Y	Y	N	Y	N	Y	N	N	N	N	N	Y	N	Y	*	N	N	Y
SF 2222 — Senate health care bill, mandated direct access to nonphysicians N	N	N	Y	N	N	N	Y	Y	N	Y	N	N	N	Y	N	Y	Y	Y	Y	N	N	*	Y	Y	N
SF 2222, S-5156 — Physician self-referral (Riordan, Lloyd-Jones) N	N	N	Y	N	N	N	Y	Y	N	Y	N	N	N	Y	N	Y	Y	Y	N	Y	N	*	Y	Y	N
HF 2376, S-5463 — Removes Tobacco Free Coalition language (Buhr-Appropriations Committee) N	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	Y	N	Y	Y	Y	N	Y	N	N	*	Y	N	N
HF 200 — Volunteer physician indemnification Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	Y	Y	Y

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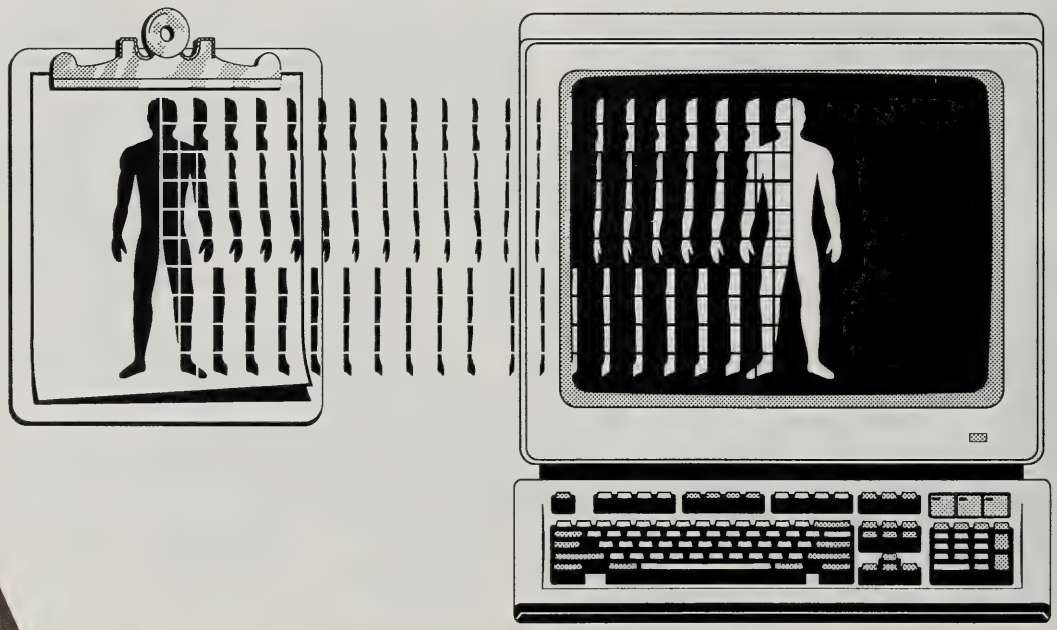
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Medical Economics

CHMIS Data Advisory Committee meets

The CHMIS Data Advisory Task Force met at the Iowa Medical Society in late May to hear presentations by two major companies regarding their severity of illness reporting systems. The 3M Company demonstrated their All-Patient Refined DRGs (APR DRGs); the Pittsburgh Research Institute demonstrated a system called Patient Management Categories (PMCs).

The task force recommended the 3M APR DRGs to the Iowa Health Data Commission (IHDC) for the severity of illness reporting system for all Iowa hospitals.

The 3M APR DRG software will operate from the commissions of the IHDC's patient discharge database (IHA statewide patient database). Public reports will be produced with severity of illness and charge data for all Iowa hospitals.

Hospitals will not be required to purchase the software, although it will be an option for hospitals looking for a severity of illness adjustment tool to incorporate into their quality assurance or continuous quality improvement process.

The withdrawal of the MedisGroups mandate will result in substantial savings to the 28 Iowa hospitals with over 100 beds currently mandated to supply MedisGroups with data.

Physician wins spat over deposition fee

An Iowa district court judge has found in favor of a physician who was challenged over what he charged to give a court deposition.

In his testimony, the physician said his fee for the deposition was set by his medical clinic and is reasonable compared to fees charged by other physicians in his specialty.

The defendants argued that doctors' charges do not represent the amount they actually receive since third party payers typically pay doctors less than their normal charges. However, the judge found that the doctor's fee was reasonable and the ruling admonished the defendants for citing "outrageous expert fees" as a factor in driving up the cost of litigation.

"If cost control is an objective," reads the judge's ruling, "defendants should examine the cost of the extensive legal proceedings concerning this dispute, which included an interlocutory appeal, numerous hearings and subpoenaes for the doctor's personal records". The judge advised attorneys and physicians to follow the principles of cooperation adopted by the Iowa Medical Society and the Iowa State Bar Association rather than engage in extensive legal proceedings.

The Iowa Medical Society filed a successful motion to intervene for purposes of participating in the hearing on the fee dispute.

Quality improvement initiative update

The Iowa Foundation for Medical Care (IFMC) has been involved in the Cooperative Cardiovascular Project (CCP) with the Health Care Financing Administration (HCFA). The study group concerning myocardial infarction has met on several occasions over the last year and a half. This group has validated data from all hospitals in Iowa treating MI patients to determine quality indicators for treatment of this disease. The group also met to discuss the continuation of the quality indicator validation and the hospital feedback visits that are planned for the summer.

There are 40 hospitals scheduled to be contacted with quality data from their hospital. HCFA is preparing a press release discussing the results of the myocardial infarction study. This information will be made available to IMS members as soon as the scheduled release is made official.

Medicaid managed mental care

This month, the Iowa Department of Human Services plans to implement a managed mental health care plan for much of Iowa's Medicaid population. A total of eight proposals were received and accepted by the May 10 deadline. The proposals were reviewed by a DHS com-

continued

AT A GLANCE

The planned merger of Blue Cross/Blue Shield plans in Iowa and Illinois has been cancelled due to differences in the corporate culture, structure and style of the two organizations. The two Blues plans announced their intent to combine operations in May, 1993. The two companies may pursue other types of alliances or joint ventures.

HCFA has delayed plans for a data bank to identify the nation's seven million Medicare and Medicaid recipients who have other health insurance plans after a report questioned its cost-effectiveness.

Relieving debt loads, increasing salaries and cutting back on hours worked could encourage more medical students to become primary care physicians, according to a recent article in JAMA.

Medical Economics

continued

mittee; announcement of the winner was planned for late June. The date was moved forward due to the complexity and volume of information contained in the request for proposals.

Watch the August *Iowa Medicine* for more information on who was awarded the Medicaid Managed Mental Health Care Plan project.

MediPASS developments

As of July 1, 1994, there will be managed care in 75 of Iowa's 99 counties.

The MediPASS program was scheduled to be implemented in all Iowa counties by July 1, 1994. This program, ongoing since October 1, 1993, will include 75 of Iowa's 99 counties by July 1, 1994. There are two HMOs participating—Heritage National Health Plan participates in 12 counties and Care Choices is in one county. Over 1,000 physicians participate in the MediPASS program.

For further information about physician participation in MediPASS, please contact the UNISYS Corporation at 800/326-4132.

Blues' physician incentive program

A new incentive program for primary care physicians in the Blue Advantage Network has been announced by Blue Cross and Blue Shield.

The program consists of two components: 1) a patient management fee; 2) an incentive award. The patient management fee recognizes a patient's primary care physician has additional responsibilities. The incentive portion gives physicians an opportunity to earn an additional award based upon results of nine key indicators. Those are: office review, medical record review, extended office hours, electronic claims submission, patient satisfaction, prescribing patterns, retroactive referrals, open practice and tenure with Blue Cross/Blue Shield of Iowa alternate delivery system products.

For more information about the patient management fee and incentive program, contact Blue Cross and Blue Shield 515/245-5167.

New outpatient reimbursement plan

On September 1, the Iowa Department of Human Services will be implementing a new reimbursement methodology for outpatient hospital services called the Ambulatory Patient Groups. Payment for claims will be retroactive to July 1 based on this ambulatory patient grouping. The following questions and answers have been posed in meetings where APGs have been presented. This information covers outpatient hospital services and will not affect physician billing practices. For more information, contact Donna Bottorff at the IMS, 515/223-1401 or 800/747-3070.

Q. How will observation visits be reimbursed?

A. Observation visits will be paid outside the APG system at an hourly rate to be determined by the Iowa Department of Human Services.

Q. How will new ICD-9-CM diagnosis codes (every October) and new CPT/HCPCS Level II codes (every January) be incorporated into the Medicaid APG system?

A. If HCFA doesn't begin using APGs and update the grouper, Medicaid will. We will evaluate all weights and recalibrate periodically, but unless a new APG is added, there will probably be no significant changes.

Q. Will Iowa Medicaid be timely in adopting annual ICD-9-CM, CPT, and HCPCS Level II codes? (Some Medicaid programs have not "adopted" the current versions of ICD-9-CM and CPT in a timely manner.)

A. We are anticipating redoing the coding each year, but we will likely be behind CPT and ICD-9 publication dates.

Q. What will the blended rates be and how long will they be phased in? For example, will the blend be 75% costs and 25% APG rate for the first year?

A. The blended rates are currently set at 50/50. We do not anticipate changing these percentages, but will look at them during future evaluation periods.

Q. Will Medicaid target certain APGs for audits or will certain APG assignments automatically trigger an audit? Will Iowa Medicaid have an "APG Code Editor"?

A. The rules contain the PRO review criteria. We do not "target" any specific APGs at the outset. Iowa has no code editor.

Q. How are medical APGs grouped?

A. The principal ICD-9-CM diagnosis is the code used to drive the medical APG assignment.

Q. Will Iowa hospitals report HCPCS Level II codes for the following services: J codes for chemotherapy drugs; H5300 for occupational therapy; Q codes for chemotherapy administration and physical therapy?

A. Yes, Iowa hospitals should report HCPCS Level II Codes.

Q. How will laboratory panel codes be addressed under the Iowa Medicaid APG system?

A. All tests should be reported separately by the hospital on the UB-92 form to assure complete APG payment.

Q. How will the Iowa Medicaid APG updates/revisions be provided?

A. Iowa will provide information to all active hospitals on the Medicaid provider files.

See the June *Iowa Medicine* for more information about Medicaid APGs. IM

Housing tax credits too good to be true?

Financial services industry often overlooks housing tax credits as one of the best techniques for reducing your federal tax liability.

One of the most effective and frequently overlooked methods of reducing federal tax liability is the Low Income Housing Tax Credit. The federal government recognizes that a tremendous gap exists between the supply and demand for affordable housing in the United States. Fortunately in response to this need, Congress has elected to present investors with a tremendous opportunity. As an incentive to develop low income housing, they authorized the use of a federal tax credit in 1986. Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

150 Percent Credit

Investors in low income housing are projected to receive tax credits equal to approximately 150% of their investment, although sometimes it can range as high as 190% of their investment. The total amount of credits is distributed equally over 10 years. For example, a $10,000 investment would yield tax savings of approximately $1500 per year for the next 10 years, for a total of $15,000. As previously stated, the total may be as high as $19,000 for every $10,000 invested. Depending on factors such as an investor's income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using Low Income Housing Tax Credits.

In addition to the credit, there are other potential benefits which can be realized. Cash flow from operations can result if the properties are profitable. This comes in the form of distribution checks sent directly to investors. Generally, all cash flow distributions are completely sheltered from taxes.

As an equity investor, you also own part of an apartment complex, in addition to the credits and cash flow. When the properties are sold, they may be sold at a profit. Again, a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Social Benefits

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The funds raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. These programs are *not* government projects, tenants must meet certain income criteria, *but their rents are not subsidized.* As in any other apartment complex, the tenants are subjected to references and employment checks to make sure they are desirable renters.

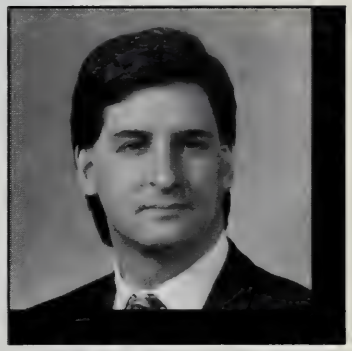
Perhaps the greatest obstacle tax credits face is that they sound too good to be true. That is, until you mention that the only form they are available in is that of a limited partnership. Any time real estate and limited partnerships are mentioned in the same breath, people are conditioned to run for their financial lives! However, these programs differ significantly from the real estate programs commonly known as "tax shelters" that were promoted in the early 1980s.

Figuratively speaking, old tax shelters granted the general partner a license to steal. The fees in the programs were exorbitant and the amount of borrowed money involved excessive. If that wasn't enough, Congress put a stake through their heart in 1986 by eliminating or postponing the tax benefits these programs were designed to deliver.

Partnerships are under much more scrutiny from investors now. Tax benefits are rarely the sole motivating force behind these investments. It should be pointed out however, that should an investor in Low Income Housing Tax Credits receive only the credit and no other benefit, they have done well. The tax credits, if fully earned, are projected to produce a respectable 6 to 14% after tax return on their money.

The other benefits such as cash flow and appreciation and use of the passive losses could enhance the return even more.

As is true of all real estate investments, housing tax credits are not without risk. Tax credits are complicated and not everyone can use them. However, in taking a survey of current and past performance of these properties indicates the results have been very favorable. Demand for affordable housing is enormous and in most markets these properties operate with occupancies in the 95-100% range. This is significantly higher than the breakeven occupancies typically around 65-75%.



Financial planner Don DeWaay says housing credits can be a gold mine for investors.

Do Your Homework

It is important to evaluate each program on its own merits. Always scrutinize the track record of the General Partner. There are always spread sheets or "pro formas" that outline the expected benefits from these investments. Compare these against actual performance on prior programs. Read the prospectus carefully, noting fees and structure of the program. It is to the investor's benefit to keep the fees below 20%. This may sound high, but when you examine what it costs to register and develop a program it is quite reasonable. Also look for programs that use lower leverage or in other terms, lower amounts of borrowed money. Commonly, projects in LIHTC use moderate to low leverage in the 50-80% range. The lower the leverage, the more likely the property is to cash flow.

Prior to investing, you should always know all the particulars about a project. Pay close attention to the real estate markets where the properties are located. Look for a solid employment base and economic growth potential. Also look for areas with high median income which allows the properties to increase rents. A good rental market will enhance the outlook for cash flow and appreciation in the properties value. In short, do your homework. Most of these programs appear to be working well, but they are not uniform at sale. Some definitely offer more potential than others.

If all this sounds too confusing or complicated, the alternative is much easier. Simply continue to write your checks to Washington every April 15th. For that, you get no liquidity, no return and your holding period is forever. When tax credit programs perform as designed, you redirect dollars that would have been used to pay taxes and put them back in your pocket to add to your net worth. With that in mind, it's easy to see why these programs are so widely used by corporations and individuals.

Don DeWaay
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Practice Management

Patient satisfaction gaining importance

Are your patients satisfied with the services provided in your office? Third party payers and the new health alliances are using patient satisfaction surveys and other assessment tools to measure patients' feelings about the care and service they receive.

If your office could use a brush-up on how to make patient satisfaction a priority, consider the IMS Services workshop on "Patient Perceptions", based on the video "It's a Dog's World". This program can be tailored for individual office teams as a 1 1/2 to 2-hour program on-site.

The program focuses on the importance of patient perceptions, identifying 'moments of truth' and action plans for emphasizing patient awareness. Cost is based on the length and location of the program.

For more information or to schedule a program, contact Barb Cannon, 800/728-5398 or 515/223-1401.

Safety and work environment

Compliance with numerous state and federal safety/work environment requirements is important for every medical office. If you need a check-up or refresher on the rules you should be following, consider attending the IMS Services seminar "Office Safety & Compliance Issues".

Topics covered include: OSHA (including formaldehyde, blood-borne pathogens, TB and the General Duty Clause), Right-to-Know, infectious waste, fire/electrical, disaster plans, CLIA, ADA and hostile work environment.

Iowa Worker's Compensation requirements and actual medical office claims experience from Iowa offices will be reviewed. An eight-point office safety program will be presented as a model for use in medical offices.

Dates and locations of this and other seminars are listed in the box below. *(Note: One IMS/Farm Bureau Dividend Coupon can be used to cover the cost of two people attending the Office Safety & Compliance Issues program.)*

Have you checked out the new Airborne Express program available through IMS Services? You could save up to 40% over your present service. Call Sandy Nelson at 800/728-5398 or 515/223-2816.

Medical Business Specialist program

For the first time, the IMS is offering a Medical Business Specialist certification to physician office staff. The program will provide certification for staff which signifies completion of a core curriculum in business operations of a medical office. Successful candidates must complete 10 program modules which vary from three to eight hours in length. For more information, call Barb Cannon at the IMS, 515/223-1401 or 800/728-5398.

Upcoming Workshops for You and Your Practice

July 12	Office Safety & Compliance Issues	Waterloo
August 17	Office Safety & Compliance Issues	Cedar Rapids
July 14	Office Team Skills	Cedar Rapids
July 18	Office Team Skills	Council Bluffs
August 12	Office Team Skills	Ft. Madison
August 4	Managing Your Office Retirement Plan and Other Benefits	West Des Moines

For more information about any workshop or seminar listed here, call Barb Cannon or Sherry Johnson at IMS Services, 515/223-2816 or 800/728-5398.

AT A GLANCE

"Retirement — Plan Ahead", the popular workshop for physicians and spouses, will be offered July 19 in Spencer and August 18 in Davenport. Participants can have an individual planning conference as part of the workshop fee. Contact Sherry Johnson at 800/728-5398 or 515/223-1401. (Fall dates are being scheduled.)

Have you completed your 1994 blood-borne pathogens training program? Initial training was required by June, 1992 and must be repeated and documented for all staff annually. If you have questions, call Barb Cannon at 800/728-5398 or 515/223-1401.

Biennial CLIA certification fees are due again starting in August, 1994. Watch for your bill from the Iowa Department of Inspections and Appeals. Call Nancy Ruziska, 515/281-4120 with questions.

Practice Management

continued

The deaf patient's perspective

Editor's note: In the Practice Management section of the June *Iowa Medicine*, the Americans with Disabilities Act and requirements for hearing-impaired patients were discussed. This month, Becky Albright of Des Moines, a hearing-impaired patient, discusses problems she has encountered in visits to physician offices.

"It can be very upsetting if information about your medical treatment is not made clear."

When I go to a doctor's office, I write down my name to let the receptionist know who I am, but when the nurse calls out my name, I usually don't know she is calling me.

If I am hospitalized, I face communication problems if some people aren't familiar with deaf people or don't have patience to write things down or talk slow for deaf people who can read lips. I'd like to know what the tests are for and I would appreciate having things explained clearly and in detail. I realize writing notes back and forth can be a pain in the neck and doctors don't have time to write down everything, but it can be very upsetting if information about your medical treatment is not made clear.

Even if the deaf patient can read lips, lipreading can also be misunderstood or inaccurate. Sometimes we miss what the doctor is saying. (Incidentally, it is difficult to read the lips of doctors with untrimmed mustaches.)

Deaf patients in offices and hospitals can be served better through use of an interpreter. An interpreter can play an important role in making sure hearing-impaired patients have the same access as other patients. The interpreter can make sure the patient understands whatever the doctors, the lab people or other professionals in the hospital say. Interpreters eliminate the need for writing back and forth.

Teletypewriters (TTY) and decoders are needed for hearing-impared patients in the hospital and would be helpful in a doctor's office which serves a lot of deaf consumers. Doctors who don't have a TTY can call through Relay Iowa, 800/735-2943, to talk to the deaf consumers.

Doctors and hospitals should contact Deaf Action Center, 266-5105, in case of emergencies. Speaking as a deaf person, I have had positive and some negative experiences while seeking medical care. IM

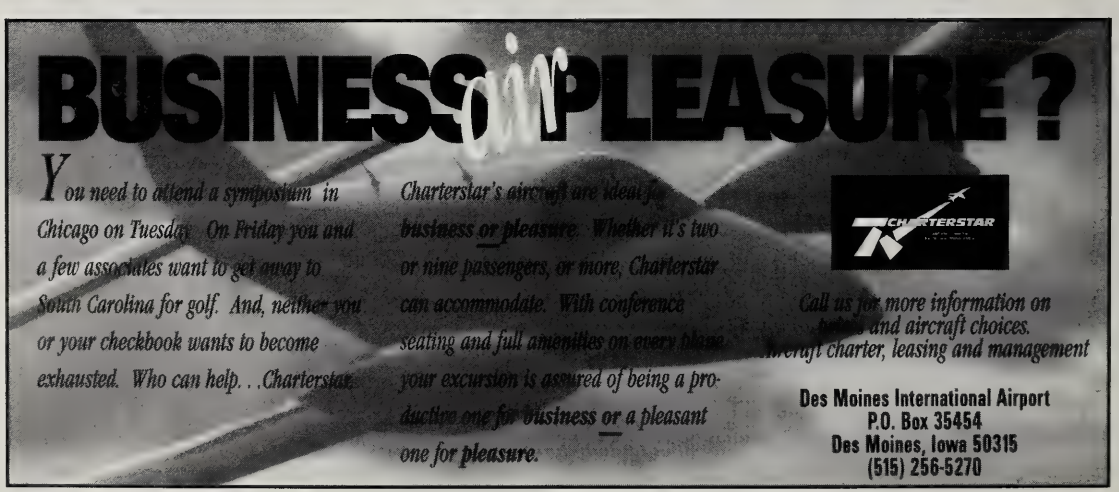
Midwest Medical Insurance Company Focus on Risk Management

Medication Alert

During the past several years, MMIC has settled a number of cases arising out of the improper administration of steroid injections. In the majority of cases, Kenalog ™ was injected into the upper arm or thigh resulting in atrophy and scarring of the surrounding tissue. Several other cases arose from steroid injections into a joint resulting in atrophy and scarring of the soft tissue at the site of the injection. The central issue in these cases was negligent nondisclosure.

All staff giving steroid injections should be instructed in their proper administration. The package insert and the *PDR* are good sources. Normally, steroid preparations are to be given deep in the gluteal muscle rather than in the extremities. Whenever a steroid preparation is given IM or intra-articularly, the patient should be advised by the physician of the risks associated with the injection and the physician should clearly document this discussion.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.



TeleMedicine

Telemedicine is use of communications technology in the practice of medicine, including computers, cameras and microphones combined with copper and fiber optic telephone lines, cable television lines, microwave signals and satellite transmissions. This introductory guide offers practical advice for physicians considering a telemedicine system and lists telemedicine's applications.

Recommendations for physicians considering a telemedicine system

Telemedicine equipment and systems are merely tools to use in practicing medicine. Physicians must be involved in developing telemedicine systems at the initial stages to ensure that the system meets their own and their patients' needs. Because of capital costs, telemedicine systems are most likely to be located in hospitals or large medical clinics. Physicians should work closely with each other and their local hospital in developing a system.

Use should drive equipment, not the reverse. As the decision is made to acquire a telemedicine system, needs and potential uses of a system should be thoroughly and creatively evaluated.

As patients and physicians become comfortable with the concept, more uses may follow.

Personnel training and support will determine success — not having the latest equipment. Be able to use the equipment you acquire. Use a level of technology you are comfortable with and upgrade when you are ready.

In assessing your needs, focus on the big picture, such as keeping your community alive or keeping quality medical services available in your community.

Telemedicine should be developed as a network for the obvious reason that you need someone to link with. If a hospital or physician's office purchases equipment, make sure the equipment is compatible with equipment used by the rest of the network. While standards for equipment are evolving, there are many proprietary systems that are not easily compatible or systems may be compatible for only basic levels of use.

Telemedicine equipment must be conveniently located — where doctors work. If it is put in an out-of-the-way place, it will be bypassed.

Lease, don't buy, your equipment if at all possible (some federal telemedicine grants require equipment purchase). Leasing allows for continuous upgrades. If a company is unwilling to lease, shop around. Refusal to lease may be a sign the manufacturer knows the equipment will soon be obsolete.

Look inside for information on potential applications of telemedicine in your practice!

Benefits of telemedicine

Telemedicine moves information instead of people. The ability to consult with a specialist in another city can replace some visits outside the patient's home. Post-surgical follow-up care, medication checks and management of chronic diseases are examples of telemedicine applications of videoconferencing now in use. These uses can reduce patient and family travel costs, time off work and the stress of being away from home.

Telemedicine is being used by psychiatrists to provide consultations and support to staff at other locations as well as preadmission patient interviews. Direct patient counseling is also done but requires training in on-camera techniques.

Physician coverage of radiography and other services can be provided nights and weekends to relieve local physicians, making practice in that community more desirable.

Patient confidence in the care received at home can increase as local physicians have access to the same information and resources available to physicians in larger towns. Patients may be less likely to travel to a larger town for medical care.

Physicians can benefit from the ability to consult "face to face" with colleagues in other communities and from educational opportunities available over a telemedicine network. While telemedicine cannot replace professional conferences where networking with colleagues occurs, continuing education opportunities and computer access to medical libraries can help support physicians in urban and rural areas.

Provided for member physicians by the Iowa Medical Society

TeleMedicine

A menu of potential uses for telemedicine in Iowa

Videoconferencing

Videoconferencing, the backbone of most telemedicine applications, allows one or more persons at one site to see and speak with one or more persons at another site. At least one camera is used at each site for video transmission in addition to microphones and other equipment for audio transmission.

Many hospitals around the country have developed special rooms with permanently installed videoconferencing equipment for medical applications. These allow a physician and patient at one site to consult with a physician at another site. Mobile units are also available which can be moved from room to room in a building or even between facilities.

Videoconferencing rooms are being developed in various locations in Iowa through some local telephone companies for public use for a fee. While these rooms are not set up for medical applications, they can be used for meetings and conferences.

Applications of videoconferencing in medical practice are many and varied. They can include consultations between physicians at different locations, examination of a patient at one site by a physician at another site, supervision of nonphysician practitioners at a remote site, consultation by a psychiatrist with a mental health team at a remote site, postsurgical follow-up visits between a patient in one community and a physician in another and a variety of educational applications. With the addition of tiny cameras attached to scopes used in examining a patient, a physician at another location can see the same images as the onsite physician.

Videoconferencing can occur at a range of transmission speeds. Traditional twisted-pair copper wire telephone line, coaxial cable such as is used for cable television, microwave signals and satellite signals are all used for videoconferencing using various transmission speeds. Compression techniques can be used to reduce the time and capacity needed to send a signal. There can be blurring or "jerkiness" when movement occurs in the video image received at lower speeds; this may be acceptable for some applications. Full motion video requires high speed transmission and is similar in quality to the signals we receive on our home television sets.

Teleradiology

Teleradiology involves the transmission and storage of both still and moving pictures. High capacity communication lines used in conjunction with the right equipment at both ends can result in high quality, high resolution images received. Images are transformed into digital format and may be compressed to reduce the needed communication capacity and electronic storage requirements. Slower transmission can be used for still images. High resolution teleradiology systems can be used for a primary diagnosis while low resolution teleradiology is appropriate for on-call support and provisional interpretation of an X-ray.

continued next page

Costs and unresolved issues

Telemedicine can be costly. Equipment for some applications can be expensive, especially for small offices. Equipment and software costs may be only a small part of setting up a system. Equally important is providing staff and physician training in use of the system and ongoing technical support. Without this support a costly system may not be used to full advantage, if at all.

Reimbursement is an unresolved issue. Medicare and Medicaid waivers have been obtained for the Medical College of Georgia's system to allow for reimbursement for physicians at each end of a telemedicine consultation link for an examination. Georgia's Blue Cross Blue Shield reportedly reimburses for some services. Reimbursement is most likely to occur for teleradiology and telepathology services, since there is no difference to the payer whether services are provided electronically as long as quality is maintained. Reimbursement for consultations over the network involving physicians at different sites is being examined for possible reimbursement. Equipment costs are not likely to be reimbursed separately although they may be included in a hospital or clinic's overhead costs.

Payers are concerned that telemedicine holds the potential for overuse or inappropriate use. Many payers are waiting for demonstrations of cost effectiveness before deciding to reimburse for some services.

There are concerns that telemedicine could replace physicians in some areas. Teleradiology opens the door to competition outside the immediate geographic area.

Practice across state lines is an unresolved issue. Does a specialist in Omaha need an Iowa license to see a patient located in Atlantic, Iowa over a telemedicine network?

Liability issues also bear further examination. Maintaining quality of care and quality of equipment are critical.

TeleMedicine

continued from previous page

Teleradiology systems can be used within a facility or between facilities. A typical use would be to provide radiography coverage nights and weekends for a community with one radiologist.

A teleradiology system consists of several components: 1) a means of acquiring image data which includes a film digitizer and an interface to the image data from a CT scan, MRI or ultrasound, etc.; 2) a display system such as an interactive gray scale display; 3) printing and storage devices such as hard-copy recorders (laser film printers and grayscale paper printers) and magnetic disk or optical disk archiving devices; 4) a wide-area network or local area network to link sending and receiving sites.

The American College of Radiology is developing a standard for teleradiology. The standard is expected to be available in October, 1994. The College has also developed a guide to teleradiology systems which is currently available. (See resources list.)

Medical records and claims data

Electronic transmission of medical records and claims data can also be classified as telemedicine. Electronic claims processing is in widespread use over the existing telephone system.

Iowa Communications Network (ICN)

Iowa's fiber optic network, the Iowa Communications Network (ICN) employs fiber optic telephone lines to transmit both voice and audio information. Fiber optic cable is made of many thin strands of pure glass which carry signals in the form of light. It has very high capacity and can transmit large quantities of information at high speed without electronic interference. Generally, the higher the speed of transmission, the better the quality of the moving image received.

Telemedicine can be used without the state network although the ICN significantly expands Iowa's potential in telemedicine through its extensive coverage of the state by fiber optic cable. Currently, the ICN has a point of presence in all Iowa counties and most school districts are expected to link to the system in the near future.

Legislation passed in 1994 allows hospitals and physicians' clinics to use the ICN for telemedicine. Details of how this can be accomplished and the charges for use are being developed.

Private telephone companies

Fiber optic cable is being widely installed by private telephone companies but is not uniformly available in all communities. Community telephone systems vary; switching equipment and type of cable affect the telemedicine applications possible through local carriers. However, not all applications require high speed, high capacity lines. Physicians interested in using telemedicine are encouraged to consult with local telephone companies about their capabilities as well as consider using the ICN.

Resources

Dyson, Peter. *Novell's Dictionary of Networking*. Novell Press. Copyright 1994.

Schiller, Arthur E. Jr. *Telecommunications: Can It Help Solve America's Health Care Problems?* Arthur D. Little, Inc., Acorn Park Cambridge, Massachusetts 02140-2390, reference 91810-98. July 1992.

Witherspoon, John P.; Johnstone, Sally M.; Wasem, Cathy J. *Rural TeleHealth: Telemedicine, Distance Education and Informatics for Rural Health Care*. Office of Rural Health Policy Health Resources and Services Administration, Department of Health and Human Services, order HRSA 92-1208.

Telemedicine: Assessing the Kansas Environment. Kansas Telemedicine Policy Group, Kansas Department of Health and Environment and Kansas Hospital Association. November 1993.

Other sources of information:

A Guide to Teleradiology Systems. American College of Radiology, Committee on Research and Technology Assessment of the Physics and Radiation Protection Commission. 1993. Free to ACR members, $10 to nonmembers (prepayment required). Available from Publications and Sales Department, American College of Radiology, 1891 Preston White Dr., Reston, VA 22090.

Proceedings of the Mayo Telemedicine Symposium, held October 1-3, 1993. Copy available free from Richard McGee, Ph.D., Consensus Conference Director, Department of Education Services, Mayo Clinic and Mayo Foundation, 200 First St. SW, Rochester, MN 55905.

TeleMedicine Glossary of terms

The communications and computer fields have their own vocabulary. Following are a few of the terms you may encounter when discussing telemedicine systems.

Analog: A continuously varying electrical signal in a shape of a wave, such as voltage in an electrical circuit. It is represented by continuous wave forms that vary in size and number as the information source varies. Analog often refers to transmission methods developed to transmit voice signals rather than high-speed digital signals.

Architecture: The design and construction of all or part of a computer system. Open architecture refers to a system design that is independent of a particular vendor and allows the user to configure the system using different components. Closed architecture does not allow for easy, user-supplied additions or for third-party companies to provide products that work with the computer system.

Bandwidth: Refers to transmission capacity, such as for a telephone line, the amount of information that can be transmitted in a given time. It is usually measured in megabits per second (Mbps) or kilobits per second (Kbps).

Baud: Measurement of data transmission speed, usually of a modem or similar device. The baud rate may correspond to bits per second but they are not always the same. Bits per second is a more accurate statement of modem capability.

Bit: Short for "binary digit". It is the smallest unit of information in digital code and is represented as "on" or "off" by the numbers "0" or "1". Used in telemedicine in measuring transmission capacity of a communications system, such as telephone or television cable, in kilobits per second (Kbps), megabits per second (Mbps), or gigabits per second (Gbps) — one thousand, one milion or one billion bits of information per second.

Byte: Equals one character in computer storage terms and is a group of 8 bits. Computer hard disk capacity or memory size is usually measured in kilobytes, megabytes or gigabytes.

Codec: A "code-decode" electrical device which converts an analog electrical signal into digital form for transmission purposes. It is used in telemedicine to transform audio and video signals into digital form for transmission.

Digital: Discrete signals such as those represented by bits (which are on or off) as opposed to continuously variable analog signals. Digital format allows communications signals to be compressed for more efficient transmission. Digital signals are measured in bits per second.

Fiber optic cable: Cables made of strands of pure glass fibers which use pulses of light rather than electricity to transmit audio, video or data signals. Optical fiber has high bandwidth in a small package. It is immune to electrical interference and has better signal-transmitting qualities than copper wire.

Full-motion video: Standard video signal that can be transmitted by a variety of means including television broadcast, microwave, fiber optics and satellite. Full-motion video traditionally requires 6 megahertz (MHz) in analog format or 45 Mbps when encoded digitally. This is broadcast quality video.

Hertz: A unit of frequency measurement. 1 Hertz equals one cycle per second. Used to measure capacity of transmissions which take place in analog format. A computer's internal speed (clock speed) is also measured in megahertz. The faster the clock speed, the faster the computer can perform a specific operation. Abbreviated as Hz.

Local-area network: A group of computers and associated devices connected by a communications channel, capable of sharing files and other resources between users. A network in a hospital is an example. Abbreviated as LAN.

Microwave: A method of radio transmission that uses high-frequency waves (in the range of 1 to 30 gigahertz) for line-of-sight communications. It requires a repeater station every 20 miles due to the curvature of the earth. Microwaves can also be used for satellite communications.

Modem: A "modulator-demodulator" device which converts digital information from a computer into analog form for transmission over a telephone line and reconverts it to digital form at the point of reception. Capacity is measured in baud or in bits per second.

Multiplexer: Equipment which merges two or more lower speed channels of voice, data or video information to be transmitted over a single high speed channel or which splits the high speed channel into lower speed channels. A single T1 telephone line can be split into a number of different channels to allow for multiple applications to be carried along the same T1 line.

Slow scan video: Device that transmits and receives still video pictures over a narrow telecommunications channel, such as standard telephone lines.

T1: A term used to describe digital telephone service with a capacity of 1.544 megabits per second (Mbps). Interactive video can be transmitted at this or somewhat lower speeds, though "jerkiness" and blurring of movement increase as speed decreases. A T1 line has a capacity equivalent to 24 standard residential telephone lines. Also known as DS-1.

T3: A term describing a carrier of 45 Mbps bandwidth which can carry up to 28 T1 channels. T3 is usually available over fiber optic cable. Also known as DS-3.

Twisted-pair cable: Telephone cable comprised of two or more pairs of copper wires twisted together. Modern telephone wire is usually twisted-pair.

Wide-area network: A network that connects users across large distances, often crossing geographical boundaries of cities or states. ICN is a wide-area network. Abbreviated WAN.

Many of these definitions were taken from *Novell's Dictionary of Networking* and *Rural TeleHealth: Telemedicine, Distance Education and Informatics for Rural Health Care.* (See the Resource list inside.)

Practice Announcement

Mark A. Templeton

announces the establishment of his private legal practice at 1003 Grand Avenue, West Des Moines, Iowa 50265. This office building is immediately west of the Iowa Medical Society headquarters.

Appointments are being accepted by calling 515/224-4639.

Mark was previously employed by the Iowa Medical Society, having served as administrator of the Iowa Psychiatric Society; Iowa Oncology Society; American College of Cardiology, Iowa Chapter; Iowa Society of Rehabilitation Medicine; American Medical Directors Association, Iowa Affiliate; and the Iowa Medical Group Management Association.

The determination of the need for legal service and the choice of a lawyer are extremely important decisions and should not be based solely upon advertisements of self-proclaimed expertise. This disclosure is required by rule of the Supreme Court of Iowa.

Newsmakers

AT A GLANCE

St. Luke's Hospital and Mercy Hospital, Davenport, have consolidated into a new organization named Genesis Medical Center.

***John Colloton**, former director of the UI Hospitals and Clinics and assistant to the president for Statewide Health Services for 23 years, received the F.P.G. "Fritz" Lattner-Iowa Hospital Association Award for 1994 at the Iowa Hospital Association's annual meeting in Des Moines. Colloton, currently UI vice president for Statewide Health Services, received the award for "vision, foresight and contribution to Iowa health care by his leadership in assuring quality health care education, research, patient care and public policy through four decades of service in the public interest."*

Credit card editorial sparks response

Dear Dr. Alberts:

Hooray for your editorial comments of May 1994!

Our financial advisers tell physicians to allow credit cards for payment of our services. That advice may be good for a while for some couples, but eventually it may cause real financial burdens.

We doctors should remain as allies to our families and avoid creating largely unnecessary financial burdens by use of credit cards.

Thanks for your timely words!—*John Gay, MD, Des Moines.*

Letter to the Editor

Awards, appointments, etc.

Dr. Edward Steinman has joined **Dr. Phillip Bryant** in practice at the Metro Medical Clinic, Des Moines. Both physicians are in family practice. **Dr. Peter Kirchner,** professor and director of the Division of Nuclear Medicine in the Department of Radiology, UI College of Medicine, has been elected president of the Institute for Clinical Positron Emision Tomography (ICP). The ICP—a national organization that promotes clinical applications of PET imaging technology—represents all active PET centers in the U.S. as well as selected foreign PET centers. Dr. Kirchner has also been appointed chairman of the Quality Assurance and Practice Certification Committee of the American College of Nuclear Physicians. **Dr. Jeffrey Boyd** has joined the McFarland Clinic in Ames. Dr. Boyd is a cardiologist who previously practiced at the Iowa Heart Center, Des Moines. **Dr. John Kasik,** chief of staff at the Iowa City Department of Veterans Affairs Medical Center and UI College of Medicine professor, recently received the American College of Physicians 1994 Laureate Award at an awards ceremony. The award is given in recognition for achievement of excellence in internal medicine in Iowa. **Dr. Roy Overton,** Mercy West Medical Clinic, has retired after 39 years with Mercy Hospital Medical Center, Des Moines. **Dr. James Collins,** Waterloo, has been named chairman of the Iowa State Board of Medical Examiners. The UI College of Medicine has extended the term of **Dr. Robert Rodnitzky** as chief of staff, Department of Neurology.

Deceased members

Edward Drew, MD, 81, general surgery, Des Moines, died June 4

J. Wesley Crossley, MD, 73, ophthalmology/otolaryngology, Osage, died January 19

New members (as of April 1994)

Altoona
James Billings, DO, family practice

Burlington
Godfrey Chithambo, MD, internal medicine

Cedar Rapids
Sanjay Shah, MD, ophthalmology

Cherokee
Brian Fulton, DO, psychiatry

Clinton
Randy Robinson, MD, family practice
Genaro Salazar, MD, pediatrics

Davenport
Karen Rhodes, DO, general practice

Des Moines
Julio Acebey, MD, radiology
Richard Bedont, MD, radiology
Nicholas De Vries, MD, radiology
Virginia Geary, MD, emergency medicine/pediatrics
Timothy Grissom, MD, radiology

Stephen Holt, DO, urology
Cassim Igram, MD, orthopedics,
P. Ruben Koehler, MD, radiology
Myo Kyaw, MD, radiology
Michael Stefan, MD, plastic surgery
Vera Stewart, MD, radiology
Frederick Strickland, DO, general practice
Ravi Vemuri, MD, infectious diseases
William Young, MD, radiology

Dewitt
Linda Hill, DO, family practice

Dubuque
J. William Richardson, MD, cardiology

Fort Dodge
Robert Ang, MD, family practice

Iowa City
Brian Adams, MD, orthopaedics
John Callaghan, MD, orthpaedics
John Canady, MD, plastic surgery/otolaryngology/head and neck surgery
Paul Munden, MD, ophthalmology

Keokuk
Devi Mikkilineni, MD, psychiatry

Knoxville
David Blanchard, DO, family practice/emergency medicine

Ottumwa
Walker Wynkoop, MD, orthopaedics

Sioux City
Matthew Owens, MD, resident
Michael Wadzinski MD, ophthalmology-vitreous/retina

Spencer
Larry Barthel, MD, family practice

Waterloo
Linda Cooley, MD, internal medicine
Brian Gerrelts, MD, general surgery
Hugh Madden, MD, general surgery
Paula McFadden, MD, anesthesia IM

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Hiring a KEY Employee

A factor in the success of your practice is your ability to attract and maintain a quality staff. Desirable employees have to be sought out and sold on the advantages of working for your practice. These authors offer tips on how to formulate a plan for recruiting, interviewing and hiring key employees.

THOMAS HAMILTON
DERRICK LUTTRELL
Mr. Hamilton and Mr. Luttrell are employed with McGladrey & Pullen, a certified public accounting and management consulting firm in Des Moines.

Talented, motivated employees do not just magically appear. Hiring a new employee is an expensive, time-consuming process. If done improperly, the hiring process can have a compounded negative effect on your practice.

A top employee is paid a higher salary and typically has more opportunities to affect the attitudes of patients, other employees and the community. Giving special attention to retaining a key employee will pay dividends for your practice.

Do you know how to get started and what issues to consider when hiring a key employee? Here are eight steps to follow:

1 Determine replacement value

Before you do anything else, determine if you really need to hire someone. Is the position open because someone resigned? Is it possible to spread the duties among other employees? Obviously, if you can avoid replacing a key employee, your practice will realize a savings.

The most difficult part of the process is defining what type of employee you want.

2 Develop a job description

If you determine the position must be filled and there is no qualified internal candidate, focus on the duties and responsibilities of the position and the type of person who can best fulfill them. To gain a broader perspective, involve key managers or advisors in developing a job description.

Often, the most difficult part of the hiring process is defining what type of employee you want. The job description should identify the reporting relationships, specific duties and responsibilities and the necessary skills, experience and education. In addition, ask your management team to focus on your organizational structure and your practice's "personality". What makes your group unique? What type of person will fit with your employees and your patient base?

Don't forget to consider the issue of who will pay relocation costs if you hire someone from out of town.



3 Create a candidate profile

Create a profile of your ideal candidate. For example, does the ideal candidate work for a competitor? Does your candidate have an MBA and basic business skills but no specific knowledge of medical practice management? Keep in mind that a trainable candidate with a business background can bring a fresh and healthy perspective into your organization.

4 Recruit

The most common way to begin the recruiting process is to place an advertisement in a local newspaper or trade publication such as the Medical Group Management Association newsletter. Writing the advertisement is tricky because the ad must attract the most qualified candidates. You might also contact colleagues who can give you leads on desirable candidates.

You might wish to hire professional recruiters who can help you locate qualified applicants. Recruiting is a specialized, time-consuming task and someone should have responsibility for coordinating and completing the project.

5 Screen

Telephone interviews with potential candidates must be handled courteously and professionally. The conversation should be brief. The objective is to obtain a resume that will enable you to make a thorough comparison between candidates. A telephone conversation also gives you an opportunity to identify salary expectations, find out why the person is searching for a job and determine their employment goals. As you accumulate a list of prospects, compare each candidate to your job description. This will meet the objectives of the evaluation process and keep everyone's focus on the standards of the job. At this stage, be sure you are not discriminating against candidates on the basis of race, sex, age or disability.

6 Interview

When your list has been narrowed to a manageable group of three to five individuals, invite local candidates for preliminary visits. This

Incentives for Administrators

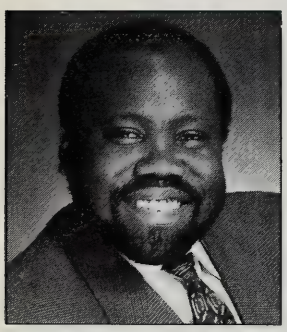
If the position you are seeking to fill is an administrator or executive director, it will be important to structure a compensation package that will not only attract qualified candidates, but keep them once they have been hired. It is not uncommon for "MBA-type" administrators to require salaries of $60,000 to $80,000. When structuring the package, include incentive compensation in addition to base wages. It insures you get the full benefit of the individual's ability. The key factor in setting incentive targets is to make the incentive obtainable and measurable so that bonus payments are simple to determine.

Since the current climate is one of stronger competition among practice groups for managed care contracts, you might relate your incentives to the environment. For example, base the bonus on a percentage of new managed care contracts brought in by the administrator. Or, base incentive compensation on reduction in accounts receivable or office overhead.

Incentives also work for administrators already employed by your practice. By establishing annual goals and offering incentive bonuses for achieving these goals, you can help retain a key employee. This also helps the administrator see the importance of their role in the overall success of the clinic.



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Derrick Luttrell is a consulting manager with McGladrey & Pullen in Des Moines. His area of concentration is medical practice management. Prior to joining McGladrey & Pullen, he was an administrator for a local medical practice.

will give you (or your interviewer) an opportunity to gauge personal chemistry before inviting the candidate back for a second interview. Obtain references during this first interview.

If your candidates live outside your local market, a telephone interview is appropriate. Check references before spending money to bring a person to your community. It is permissible to meet a candidate at a neutral site, though both parties benefit if the candidate comes to your community. This will help them gauge the workplace atmosphere and the culture of the community.

Remember that recruiting is actually selling. If you begin to develop a good relationship with a prospective candidate, be prepared to talk in detail about how the candidate can meet his or her personal goals by accepting your position. (If you've done your homework, you should know their goals.) If the candidate is from out of town, be ready to discuss the advantages of your community.

After you have interviewed an adequate number of candidates, determine if there is a qualified candidate who is the front runner to you and your selection team. That's the person you should bring back for another visit. Other key staff members should be involved in the second interview. During a second visit, it is also appropriate to introduce the candidate to support staff.

7 Make an offer

When you choose a finalist, make sure you consider the person's financial expectations and any necessary relocation arrangements. This is an area where a third party can be helpful in negotiating a "win-win" situation which works best for everyone. A third party can also gauge the feelings of both the candidate and the practice and then counsel both parties to an equitable arrangement.

It is possible the person's present employer will attempt to match your offer. Your strategy is to prepare your candidate for this contingency. The best way to do this is to help the prospective employee make the resignation a non-monetary issue. Stress the excitement of a new employment opportunity. Tactfully suggest that your salary offer not be shared with the candidate's present employer.

Often, the present employer promises to make changes if the employee will stay. However, the promised changes rarely happen.

8 Keep in touch

During the transition period, find reasons to stay in touch with your new hire. Begin building a relationship before the employee's first day on the job. It is appropriate to invite the new hire to a practice function or meeting or to send the new employee information they might find interesting or useful before starting the new job. Consider inviting the individual for a luncheon in order to begin building enthusiasm for the new employee among your staff and ensure the person is accepted.

During the transition period, find reasons to stay in touch with your new hire.

Recruiting and managing people is hard work. Talented, motivated employees have to be sought out and sold on the advantages of joining your practice. Since people are your biggest investment, care for them as you do every other asset in your organization. IM

1994 IMS House of Delegates Proceedings

The 1994 annual meeting of the Iowa Medical Society House of Delegates was held April 16-17 at the Des Moines Savery Hotel. House sessions were chaired by Donald Kahle, MD, speaker. A Forum on Health System Reform was held April 16, followed by open hearings of three reference committees. The annual banquet was held April 16 and was chaired by John Anderson, MD, IMS president.

Award winners

At the annual banquet, Jackson Ver Steeg, MD, a Des Moines anesthesiologist, received the 1994 IMS Merit Award. Dr. Paul Seebohm, Iowa City, received the Society's Distinguished Service Award. Dr. Peter Wallace, an Iowa City pediatrician, received the IMS Physician Community Service Award. Jack McDermott, manager of Orthopedic Surgery Associates in Davenport, received the IMS Outstanding Medical Office Administrator Award. Don Neumann and Tina Preftakes, IMS staff members, received the Society's John F. Sanford Award.

April 16 session

Registered for the April 16 session of the House were 149 physician delegates. Minutes of the 1993 House of Delegates session were approved as summarized in the July, 1993 issue of Iowa Medicine.

New delegates to the House were introduced and reference committee appointments were announced.

Dr. Nancy Dickey, AMA trustee, and Dr. Robert Shapiro, president of the Nebraska Medical Association, were introduced and information regarding the House agenda was reviewed.

Two checks totalling over $25,000 were presented on behalf of the AMA-Education and Research Foundation to Dr. Richard Lynch, interim dean, University of Iowa College of Medicine. The funds, raised primarily through the efforts of the IMS Alliance, are to be utilized by the U of I College of Medicine's excellence fund and assistance fund.

Reports to the House

Reports contained in the 1994 House of Delegates handbook were approved, except for page 11 of the report from the Committee on Articles and Bylaws, which was referred to the Reference Committee on Reports of Officers and Articles and Bylaws.

Supplemental reports from the Board of Trustees and three committees were referred to reference committees. The necrology report was presented by Dr. Robert Kent, chairman of the IMS Judicial Council, with delegates observing a moment of silence in honor of deceased physicians.

Informational reports were submitted by the IMS Education Fund, IMS Services and the Iowa Foundation for Medical Care. Dr. John Anderson presented his address as outgoing IMS president, stressing the importance of physician unity in the face of a dynamic health system reform debate. Dr. Anderson received a standing tribute for his leadership during the past year.

IMS officers for 1994-95

The report of the Nominating Committee was read. Since no candidate for office was opposed, a motion to elect the following slate of officers by acclamation was approved:

President	Joseph Hall, MD, Des Moines
Vice president	Siroos Shirazi, MD, Iowa City
Trustee (3-year term)	John Brinkman, MD, Mason City
Speaker, House of Delegates	Donald Kahle, MD, Dubuque
Vice speaker	Tom Throckmorton, MD, Spencer
AMA delegate	Clarence Denser, Jr., MD, Des Moines
(2-year term)	Bruce Trimble, MD, Mason City
	Donald Young, MD, Solon
AMA alternate delegate (2-year term)	Thomas Graham, MD, Iowa Falls

Six District Councilors were also chosen. They are: Eugene Kerns, MD, Davenport (District III); Steven Erickson, MD, Cedar Falls (District VII); Leo Milleman, MD, Ames (District VIII); John Fernandez, MD, Council Bluffs (District XII); Kathryn Opheim, MD, Sioux City (District XV); and Michael Disbro, MD, Des Moines (District X).

Ten resolutions submitted by county societies, councilor districts and others were formally introduced and referred to reference committees. Actions taken on those resolutions are reported subsequently.

The speaker presented information on the Reference Committee hearings and the concluding session of the IMS House of Delegates. The House recessed at 10:00 a.m. to prepare for the Forum on Health System Reform at 10:30 a.m.

Life members

The following physicians were elected to life membership in the Iowa Medical Society. (Life members are physicains who have practiced medicine for 50 years and have been members of the IMS for 15 consecutive years):

Charles Beckman, MD, Kalona; **Edmund Burke, MD**, Adel; **Loran Coppoc, MD**, Iowa City; **David Culp, MD**, Iowa City; **Mary Dewey, MD**, Iowa City; **Paul Ekart, MD**, Ottumwa; **Roland Erikson, MD**, Davenport; **John Hennessey, MD**, Manilla; **Hal Hirleman, MD**, Cedar Rapids; **Robert Hoffman, MD**, Des Moines; **Van Hunt, MD**, Mason City; **Newell Ingle, MD**, Cedar Rapids; **John MacGregor, MD**, Mason City; **John McCoy, MD**, Cedar Falls; **John Moberly, MD**, Dubuque; **Ranald Olson, MD**, Muscatine; **Robert Pfaff, MD**, Dubuque;

Richard Paul, MD, Des Moines; **Christian Schrock, MD**, Iowa City; **Ian Smith, MD**, Iowa City; **Jack Spevak, MD**, Des Moines; **Robert Storck, MD**, Dubuque; **John Tiedeman, MD**, Sioux City; **John Westly, MD**, Mason City; **James Widmer, MD**, Wayland; **James Young, MD**, Clinton.

Emeritus IMS membership was accorded to 47 physicians.

April 17 session

Registered for the April 17 session of the House were 104 delegates. Minutes of the April 16 session were read and approved.

Mrs. Judy Hoenk, past president of the Iowa Medical Society Alliance, addressed the delegates regarding Alliance projects during the past year. Mrs. Sharon Scott, president-elect of the American Medical Association Alliance, also addressed the House.

The House of Delegates acted on reports from three reference committees and the speaker acknowledged the efforts of the committees. The House was adjourned and James White, MD of Dubuque was installed as president for the coming year.

Organizational meetings of the IMS Board of Trustees and Judicial Council occurred following Dr. White's installation.

House of Delegates policy actions

Reports considered by the 1994 House of Delegates came from the Reference Committee on Medical Service and Miscellaneous Business, the Reference Committee on Legislation and the Reference Committee on Reports of Officers and Articles of Incorporation and Bylaws. Based on consideration of the reports, the IMS will take the following actions:

- Increase 1995 IMS dues by $10.
- Review the written principles of the Society for possible revision by the 1995 House of Delegates.
- Consider the issue of organ donation and consider working with other organizations to review policies and educational programs related to organ donation.
- Adopt the policy that surgery, including laser surgery, be performed only by individuals licensed to practice medicine and surgery. This resolution is referred to the Board of Trustees for consideration of how to support its intent and educate the public on the differences in education and training of physicians and nonphysician practitioners.
- Do everything in its power to establish a statewide universal Medicare payment schedule.
- Do everything in its power to ensure the total budget dollars stay within Iowa if granted the single Medicare payment locality status.
- Work with the AMA to pursue all avenues to maintain confidentiality of information collected within the National Practitioner Data Bank and assure this is a cost-effective method for collecting data.
- Refer the following resolution to the appropriate committee for further study and recommendation: That the IMS Board of Trustees appoint a committee to recommend a policy on detecting, diagnosing and treating drug use by pregnant patients.
- Work with the AMA to bring about reevaluation of criteria and regulations imposed by the Clinical Laboratory Improvement Amendments Act (CLIA) emphasizing the benefits for patients of using qualified physician laboratories.
- All physicians should have the right to apply to any managed care entity and be judged for admission based on physician-developed objective criteria, based primarily on professional competence and quality of care.
- Managed care organizations should be required to disclose to physicians criteria used to select, retain or exclude a physician, including the criteria used to determine geographic distribution and number of specialty physicians needed.
- Oppose any legislation which would require a managed care entity such as an independent physicians association (IPA), health maintenance organization (HMO), organized delivery system (ODS) or physician organization (PO) to admit any physician or limited health care practitioner solely on the basis that the practitioner is willing to abide by the requirements of the entity.
- Affirms support for AMA policy that witnesses be required to have comparable education, training and occupational experience in the same field as the defendant; that the occupational experience include active medical practice or teaching experience in the same field as the defendant; and that the active medical practice or teaching experience be within five years of the date of the occurrence giving rise to the claim.
- Reaffirms support of .05 percent blood alcohol level as per se illegal for driving.
- Support a policy where .02 percent blood alcohol content is considered the legal level of intoxication for drivers under age 21.
- Advise appropriate persons of IMS perspective on release of data by HCFA regarding the Cooperative Cardiovascular Project and the Developing and Evaluating Methods to Promote Ambulatory Care Quality project because of the lack of reliability in the data.
- Change the IMS bylaws to eliminate all but four standing committees (Legislation, Medical Education, Medical Service and Nominations), shift the duties of the Grievance Committee to the Judicial Council and permit the IMS President, Board of Trustees and House of Delegates to appoint or reappoint any special committee or task force on an annual basis and to abolish a special committee or task force after its assignment has been completed.

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The Journal
of the Iowa Medical Society

Leprosy in Iowa: 1955-1990

● RICHARD CAPLAN, MD

Editor's note: This is the second part of a 2-part series on the importation of Hansen's Disease into Iowa.

My next sources include the patient diagnostic file from University Hospitals in Iowa City, the only large, comprehensive tertiary care center in the state, and from data at the Iowa State Department of Health, provided through the courtesy of Dr. Russell Currier. Because of various re-locations and purgings of the files, my data from the University Hospitals was available only after 1928 and from the Iowa State Department of Health after World War II.

The next case I could locate dates from 1955, which, if correct, means HD was absent from Iowa during the 72-year gap between 1883 and 1955. (However, the medical record at University Hospitals for the patient first seen in 1955 contained a letter from a physician at the State Department of Health, dated June 21, 1956, in which he speaks of "our last case reported from Jackson County." That patient, not otherwise identified, contracted the disease "as a child in California." He married a girl from Jackson County and came to work on her family farm. "Because of loss of feeling in his hands, farm work caused so many injuries that he was unable to continue it. We helped him secure a job as a draftsman with an aeronautics company. He has since transferred to Colorado." The diagnosis of leprosy for this man may be correct, but I have no substantiation.)

Below-knee amputation

Now I will describe the patients in Iowa from 1955 to 1990, beginning with two siblings who were referred to University Hospitals. They were born in 1941 and 1942 to an American serviceman and a Samoan woman. In 1951 they came to live with their paternal grandmother near Mason City, Iowa. The boy (C.E.B.), at an unstated early age, developed a Charcot joint at his right ankle along with associated anesthesia and depigmentation of that extremity. Biopsies of skin and nerve showed acid-fast bacilli.

At the Carville National Leprosarium in Louisiana the diagnosis was confirmed and a below-knee amputation performed. A follow-up note from the family doctor in 1962 said the young man was then a junior student in high school and at an examination at Carville the prior summer was said to be in good condition.

That patient's sister (C.L.B.), 14 months younger, also lived in Samoa until 1951 where both children were in contact with relatives who had HD. Both children were said to have had yaws when young and received arsenical treatment for that. The girl had spotty areas of hypesthesia on her hands, a large area of cutaneous anesthesia on her left leg and numerous anesthetic scars on both legs. Although no organisms were recovered on her nasal smears or biopsies, the pattern of nerve degeneration, the positive lepromin test and other clinical circumstances justified a diagnosis of tuberculoid or pauci-bacillary HD. In 1961 she was delivered of a second normal child at University Hospitals and in 1962 had a diagnosis of endometriosis.

The next confirmed instance occurred in 1962, a man of 35 (L.P.), born in Iowa, who grew up in Nebraska. During the seven years before coming to our clinic he served as a Lutheran missionary directing a leprosarium in Borneo. He presented with a single anesthetic lesion on the skin near his left ankle.

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for July 1994.

RICHARD CAPLAN, MD
Dr. Caplan is a professor of dermatology and coordinator of the program in medical humanities, University of Iowa College of Medicine.

Leprosy in Iowa: 1955-1990

continued

The biopsy confirmed tuberculoid leprosy. He responded slowly but satisfactorily to treatment with Dapsone.

The fourth case came to our dermatology clinic three months later, when the staff was still excited about the diagnosis in the Borneo missionary and was primed with information about the disease. A resident physician, Dr. Dan Bovenmyer, now of Davenport, made the diagnosis clinically in about 30 seconds. It was confirmed histologically. The patient (A.S.) was a laboratory worker at University Hospitals who developed a lesion on her dorsal right hand about three months earlier. She said it had numbness and decreased pain sensitivity. She was a native of Thailand, 33 years old, who had last been in Thailand four years earlier. She had no knowledge of contact with anyone having the disease. She responded well to treatment and the following year returned to Thailand, taking a year's supply of Dapsone.

Husband in foreign service

The fifth patient (N.L.) was a native Iowan, age 34, whose husband was in the foreign service, so that she "travelled extensively in the Far East, and spent the prior 4½ years in Africa." In April, 1966, three months before coming to University Hospitals, she developed scattered erythematous plaques which were hypesthetic and showed a positive histamine test. The skin biopsy was strongly consistent with tuberculoid leprosy. The patient was sent to the leprosarium at Carville for further examination and care.

The sixth patient (U.N.), born in Bombay, India, was seen in 1970 at age 27. The wife of a professor at Iowa State University, she presented several anesthetic patches. The biopsy was confirmatory with no bacilli seen. The patient was unaware of specific contact with infected patients, but had lived many years in an area of high prevalence.

The seventh case was sent to University Hospitals in 1971 with the diagnosis of tuberculoid leprosy made by an astute family doctor, Dr. Don Weideman of Vinton. The patient (V.W.) was a native Thai who had married an Iowan and had moved to Iowa three years earlier. Eight months before coming to the University she developed a 10 × 10 cm enlarging lesion on her right arm. It was indurated, scaly and its center was numb. Three months before we saw her she developed a depigmented patch on her right cheek. The biopsy was consistent with tuberculoid HD.

The eighth case (W.M.) was another native Thai, a graduate student in engineering at Iowa State University, age 27, who presented at University Hospitals in 1976 with a 1½ year history of a 4 cm hyperpigmented patch on his dorsal right foot that was numb and parasthetic. Soon after, he developed an area of mild numbness on the right lateral calf. The peroneal nerve on that side was slightly enlarged. Three months later, with Dapsone treatment, his sensation and hyperpigmentation were improving.

The ninth case arrived in 1981, a 29-year-old Korean woman (P.M.) who came for reconstruction of a collapsed nasal bridge. She was then taking Dapsone and Rifampin. She had married an Iowan. Specimens of nasal cartilage and tissue examined microscopically revealed bacilli positive with Fite's stain.

The tenth case was a 30-year-old physician (S.A.) from India taking a residency in an Iowa hospital during the previous three years. He grew up in the Punjab with his only known exposure occurring while he was in medical school. Two years earlier, in 1982, he noticed some numbness on the side of his left foot with occasional shooting pains in that same area. Five months earlier he began to have a band of numbness along his left calf. Biopsy of his enlarged sural nerve showed granulomas consistent with tuberculoid leprosy. He was responding to treatment with Dapsone and Rifampin within a few months, when he moved to Seattle.

Migrant worker

The eleventh case was first seen in 1984. In marked contrast to the other cases of this century, this 19-year-old migrant worker (R.S.) from Mexico had florid lepromatous disease with abundant large nodules and plaques on his face, ears and elsewhere and a strikingly positive nasal smear. He had come to the U.S. four years earlier, first to the Chicago area and then to Davenport, Iowa. He said a physician in Mexico some five or six years earlier had taken a piece of skin

from a numb white spot near his right elbow and then gave him medicine to take for a year. Treatment in Iowa was begun with Dapsone and Rifampin and he was transferred to Carville, where he remained under residential treatment for three years. He was discharged for follow-up care at a regional center in Chicago.

The twelfth confirmed case was a 10-year-old Vietnamese refugee boy (P.C.) who came in 1986 to live with a foster family near Iowa City. He was referred for assistance with a sensory and motor deficit below his right elbow that included a marked claw hand. My skin examination was not helpful; a nasal smear and two punch biopsies showed no abnormalities. At open surgery on his hand for attempted tendon transplant, however, his digital nerves were found to be thickened; microscopic examination confirmed tuberculoid HD. He has been receiving drug therapy and further training for his hand.

In addition to these 12 confirmed instances, Dr. Richard Lloyd, a dermatologist of Ames, Iowa, recalled seeing two students at Iowa State University in the early 1980s, both natives of India, who had skin lesions of probable tuberculoid leprosy. He could not recall the clinical details, or whether confirmation had occurred. He had not been caring for them.

Also, public health surveillance reports told of a Vietnamese man born in 1936 who in 1981 visited his student son in Iowa City. His diagnosis, according to the scant information available, was borderline leprosy. I discovered the son's address was about one block from my home in Iowa City. One other patient, also a Vietnamese, with borderline disease who had spent some time in the Philippines, came to Sioux City, Iowa to visit relatives in 1981-82. He was 23 years old then, but I know nothing else of him. These two patients, visitors to Iowa with surveillance reports sent to the State Department of Health, were probably under treatment and being followed appropriately elsewhere.

Total of 12 confirmed cases

Thus for the period 1955-1990 I have collected a total of 12 persons with satisfactory confirmation of the disease, plus three more who probably were infected and lived in Iowa for a relatively short time, plus two probably-confirmed patients who visited the state for what was likely only a short while. Of the 12 confirmed instances, six were men and six women, one had florid lepromatous disease and the others probably had the tuberculoid variety, although it is not possible to assign their clinical status precisely using current nomenclature. The countries of origin where the 12 confirmed infections were likely acquired were: Samoa, 2; Borneo, 1; Thailand, 3; India, 2; Vietnam, 1; Korea, 1; Mexico, 1; and one somewhere in the Far East or Africa.

One final patient needs special mention. He was from Sierra Leone, a five to six-year-old chimpanzee purchased in 1974 for the animal colony at the University of Iowa. He and nine other chimps were brought for studies on the infectivity of bovine leukemia virus, with which he was inoculated in December, 1974. The following February he was noted to have a maculopapular rash on the thighs which spread to involve the entire trunk and limbs. Thickening of his ear margins were seen the following June. A biopsy from that area showed many intracellular acid-fast bacilli positive with Fite's stain.

In the subsequent 14 months he developed many other nodules on the lip, nostrils, nasal septum, eyebrows, wrist and scrotum. Additional biopsies showed acid-fast bacilli within dermal nerves as well as large numbers of them in nasal smears. He died 33 months after arrival during a routine anesthetic induction. Post-mortem studies demonstrated widespread invasion with acid-fast bacteria, that were ultimately shown through sophisticated research techniques to be *Mycobacterium leprae* and not any other of the many *Mycobacteria* that are widely distributed in nature. This chimpanzee, reported by our veterinarian Dr. Kelley Donham, is apparently the first instance in a non-human primate proved to have the human disease.[10-12]

The story of this animal and the studies done are fascinating but too long to detail here. Dr. Donham tells me a few other instances have since been reported in non-human primates and occasionally in other animals, the most noteworthy being the nine-banded armadillo. Evidence is mounting that HD needs to be counted as a zoonosis and

Leprosy in Iowa: 1955-1990

continued

not an infection transferable solely by person-to-person contact.[13]

Contagiousness of HD

We are entitled to feel uncertain about just what disease or diseases might have been encountered in biblical times under the Hebrew name T'saarat. Whatever it was, it led to the priestly rules for "diagnosis and therapy" recounted in Leviticus, Chapter 13. The diagnostic criteria and the course of illness described there cannot be reconciled with HD as we know it, largely because the biblical affliction carried its great importance as a mark of religious impurity more than as a clinical entity.

In medieval times the exclusion of "lepers" from their communities and their obligation to ring bells or sound clappers with cries of "unclean, unclean" suggests the populace believed the disease to be communicable and not inherited or dietary, although even in the Middle Ages some persons believed the eating of rotten fish was the main cause.[14] Medical experts by the mid-19th century became convinced the disease was hereditary; arguments to isolate the afflicted were therefore attempting to blockade marriage, sexual congress and the production of afflicted children.

Likewise, a report of the Royal College of Physicians of London in 1876 declared: "The all but unanimous conviction of the most experienced observers in different parts of the world is quite opposed to the belief that leprosy is contagious or communicable by proximity or contact with the diseased."[15] An error like that becomes understandable in light of what we now recognize as the highly variable and lengthy incubation or latency time for this disease—anywhere from perhaps three months to 40 years. By 1887, the Royal College modified its position somewhat and reported that "The committee are quite aware that there is much difference of opinion respecting the communicability of leprosy . . ."[15]

Gradually, the bacillary, communicable nature of the disease became accepted, even though Sir Jonathan Hutchinson in 1906 published a large book that sought to prove the disease was caused by eating partially rotted or improperly cured fish.[1] Part of the slowness of accepting the bacillary cause arose because the *M. leprae* has never been cultured *in vitro*, and thus, Koch's formal postulates of proof have never been fulfilled.

Leprosy still a risk

Until socio-economic conditions greatly improve for the world's population, and/or early case-finding and treatment become extremely effective, and/or a successful vaccine and program for its use can be developed, any part of today's world remains at risk for the occasional appearance of an infected newcomer. The transmission of HD to Iowa from Norway seems unlikely ever to be repeated. Isolated cases, however, certainly remain possible for Iowa; even a case cluster might occur in the event of some larger migration of persons from an endemic area, as is still happening in other parts of the U.S.

An encouraging prospect is the action by the assembly of the World Health Organization which in 1991 adopted a resolution committing itself to a goal of the elimination of HD as a public health problem by the year 2000. However, the prospect of an expanding reservoir of infected armadillos in Texas or the Southeast, increasing in their numbers and extent of their geographical habitat, also provides reason for continued vigilance, which I deem to be the ultimate lesson of this little saga concerning leprosy in Iowa.

References

References noted in this article are available from the author or the editors of *Iowa Medicine.*

Addendum: In April, 1994, another patient with Hansen's disease came to the University of Iowa Hospitals and Clinics. A 46-year-old native of south India, he had moved in 1975 to Saudi Arabia and in 1983 to central Iowa, where he has remained. He denies knowledge of close contact with any infected person. He claimed to have noticed large scaling, hyperpigmented areas involving the right upper extremity and the medial right ankle about one year earlier. The areas, hypesthetic to light touch and pin-prick, on biopsy showed many individual and clumped organisms of *M. leprae* in foamy histiocytes. Treatment for this instance of borderline lepromatous disease was begun with Dapsone and rifampicin. IM

The physician office team

I have long been profoundly convinced that in the very nature of things, employers and employees are partners, not enemies; that their interests are common, not opposed; that in the long run the success of each is dependent upon the success of the other.

John D. Rockefeller

Though these are the words of an oil magnate/philanthropist, they pertain as well to medical office management. The relationship of employer-employee in a medical clinic is unique because of the close relationship both have with the patients (clients). Because the office staff is so intimately involved in patient care, the medical profession depends heavily upon their abilities and work ethic. Employees must understand that the single most important goal is providing compassionate and competent health care.

Patients relate closely to the employees of a physician; a bond often exists between the nurse and the patient, as well as between the physician and the patient. This is especially prevalent in the smaller clinic or physician office. The nurse assumes a greater responsibility because of the frequent questions from patients who "don't want to bother the doctor."

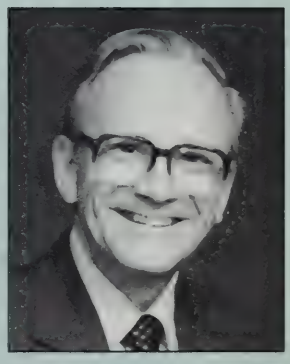
The doctor-patient relationship begins with front office employees. The efficient and attentive receptionist sets the tone of the office visit. Likewise, the nursing staff can make the transition from the reception area to the clinical facilities a smooth one. A kind word, a smile and compassionate demeanor helps the patient feel better about visiting the doctor.

The physician is an integral part of the office team effort. Considerate, unhurried, caring attitudes strenghthen this team effort. A good "bedside manner" is needed in the office, too.

The other team members are in the clerical arena. Patients have questions and often understand little about billing procedures and insurance forms. The bookkeeper must be a team player who provides thoughtful, thorough assistance.

The well-run medical office is a delightful workplace where one person out of step cannot be tolerated. It is the responsibility of the physician — or, in some cases the office manager — to provide a good working environment. However, the physician has ultimate responsibility to hire competent and caring employees, provide a pleasant office environment, pay competitive salaries and benefits and insist that every patient be treated in a pleasant manner. If you experience a high employee turnover rate, something is wrong. Seek help from a professional management consultant. The wise physician will provide quality health care and adhere to sound business principles in the office setting. IM

If you experience a high employee turnover rate, something is wrong.



Marion Alberts, MD

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Dr. Oliver Wendell Holmes



Richard Caplan, MD

Curiosity finally won; I read a biography of Oliver Wendell Holmes. It was written by his wife's nephew, John Morse, only two years after Holmes' death in 1894. Most serious Sherlock Holmes fans — and I admit to that — grant that Sir Arthur Conan Doyle probably chose the name Holmes for his detective hero in homage to the famous Boston physician, teacher, poet and essayist. I'd long had a vague awareness of him as a man of great accomplishment and renown; when young I'd been exposed to at least four of his best-known poems: "Old Ironsides", "The Chambered Nautilus", "The Last Leaf" and "The One-Hoss Shay". Years later I'd enjoyed greatly his essays packaged as *The Autocrat of the Breakfast-Table.*

I'd read tidbits of medical information, especially a reprinted copy of his paper from 1834 (*On the Contagiousness of Puerperal Fever*) in which he draws the conclusion that the disorder is transmitted to the woman at delivery by caregivers. This was 13 years ahead of the now-famous publication of Ignaz Semmelweis, written without knowledge of Holmes' paper, which argued the case with more quantitative epidemiologic data and urged hand-washing on those who deliver a baby.

Holmes contributed "anesthesia" and "anesthetic" to our vocabulary.

In addition to his excellence and popularity as an anatomy lecturer at Harvard and his service as dean of that medical school, Holmes contributed the words "anesthesia" and "anesthetic" to our vocabulary shortly after the crucial "ether-dome" demonstration at Massachusetts General in 1846. He was also the originator of the phrase "Boston Brahmin". When a new magazine was founded in Boston, its editor, James Russell Lowell, enticed Holmes to write essays for it that became the "breakfast table" volumes and accepted Holmes' suggestion the magazine be called *The Atlantic Monthly.*

A little-remembered detail about Holmes was his invention of the instrument he named the stereoscope. That vehicle of education and entertainment would have made him wealthy indeed, had he only bothered to patent it. Before his death at age 85 he clearly prized the accomplishments of his oldest child and namesake, who by then was a member of the Massachusetts Supreme Court and in 1902 would become one of this nation's greatest U.S. Supreme Court justices.

Another memory of my own was Dr. Holmes' famous remark that if the entire materia medica were dropped into the ocean, it would be so much the better for mankind and so much the worse for the fishes. Not usually recalled is that the comment began by excepting opium and fermented spirits from his therapeutic nihilism, which was likely appropriate in the mid-1800s. Although his comment is less applicable today, a measure of realistic cynicism is warranted about the risks and benefits of modern pharmacologic agents; much of today's armamentarium would still bring big problems to the fishes.

For these and other things, the gentle, beloved Dr. Holmes deserves to be remembered. IM

Classified Advertising

Emergency Medicine Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Marshalltown, Iowa—Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Numerous other Iowa locales. ACUTE CARE, INC., P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

General Surgeon BE/BC—The Department of Surgery at the Mayo Clinic in conjunction with the Decorah Clinic is seeking a broad-based general surgeon to join the Mayo Regional Facility in Decorah, Iowa, 70 miles south of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 9-person, Mayo-affiliated medical clinic in this town of about 8,100 with a 60-bed hospital and a county population of 26,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise and excellent salary and benefits. Inquiries to Michael G. Sarr, MD, Department of Surgery, Mayo Clinic, Rochester, Minnesota 55905. Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

General Surgeon—Wanted to join primary care group of 8 established physicians with a captive on-site referral base. This position offers outstanding professional, financial and lifestyle opportunities with outstanding school system. Please call Linda Cohrt, Family Medical Center (515/673-6762) or mail CV to 1225 C Avenue East, Oskaloosa, Iowa 52577; fax 515/672-2258.

Opportunities Available—Family practice, general surgeon, emergency medicine, internal medicine, locums, ob/gyn, occupational medicine, pediatrics, urgent care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, Minnesota 55430; 1-800/248-4921 or 612/574-7627.

Emergency Medicine Locum Tenens

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Practice Announcement

Mark A. Templeton announces the establishment of his private legal practice at 1003 Grand Avenue, West Des Moines, Iowa 50265. This office building is immediately west of the Iowa Medical Society headquarters.

Appointments are being accepted by calling 515/224-4639.

Mark was previously employed by the Iowa Medical Society as manager of specialty services.

The determination of the need for legal service and the choice of a lawyer are extremely important decisions and should not be based solely upon advertisements of self-proclaimed expertise. This disclosure is required by rule of the Supreme Court of Iowa.

Family Practice, Carroll, Iowa—Outstanding professional opportunities for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197, or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Emergency Medicine Spencer, Iowa

Immediate opportunity for primary care trained or experienced emergency physician. Spencer Municipal Hospital is a progressive 131-bed hospital with a staff of 30 physicians representing major specialties. 8400 volume/24-hour shifts. Spencer is a community where country charm and modern lifestyles go hand in hand. Vacation year round on the Iowa Great Lakes of Lake Okoboji and Spirit Lake. Spencer also has a variety of restaurants and shops, much more than typically found in a community of 12,000. Highly rated award winning schools make Spencer an excellent place to raise a family. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Equipment for Sale—IMEX Mascot D201, Vascular Doppler, 2 scopes, never been used. $795.00 brand new, asking $600. Contact Dr. Donald A. MacKenzie, 515/967-3996.

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Family Practice, Fairfield, Iowa—Over $100,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

Family Practice, Minnesota—BC/BE family practitioner to expand current 23-member department. Enjoy a lifestyle of call every 21-23 days and an average 4-day work week. Just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of group earn a highly competitive income and excellent benefits including paid vacation and CME, pension plan, all insurances paid. Please respond with CV to John Bordwell, MD, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-7035.

Fairfield Psychiatric Clinic, Fairfield, Iowa—is pursuing a board certified or board eligible adolescent or adult psychiatrist to join our practice of one adult phychiatrist and one licensed clinical social worker. An unexpected vacancy opening July 1 presents an excellent opportunity to step into a well rounded, busy, successful practice as a full partner. We are seeking an energetic, well balanced clinician competent in biologic and psychotherapeutic therapies. Jefferson County Hospital, adjacent to the Fairfield Psychiatric Clinic, has recently completed a new 16-bed psychiatric unit that consists of a 10-bed adult unit and a 6-bed adolescent unit. Fairfield is the county seat for Jefferson County. The practice serves a rural population of approximately 100,000. Fairfield, a progressive community of 10,000, is a university town close to cultural attractions providing excellent educational opportunities in a very friendly and caring community. Fairfield is situated in the rolling, tree covered hills of southeast Iowa. There are 3 state parks within 20 minutes with hiking, water sports, bike trails and hunting. Fairfield's schools rank among the best in Iowa and is a great place to safely raise a family. Financial package available. Call or write Russ England, M.D., Fairfield Psychiatric Clinic, 300 South Maple, Fairfield, Iowa 52556. Phone 515/472-7216 or you may contact Walt Brownlee, CEO, Jefferson County Hospital, 400 Highland, Fairfield, Iowa 52556 or call 515/472-4111.

Emergency Medicine Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

BC/BE Internist—For 84-physician multispecialty group on the scenic bluffs overlooking the Mississippi River where Iowa, Illinois and Wisconsin meet. Excellent call schedule in this 17-member department of physician-owned clinic with its own HMO. Professional administration enables physicians to concentrate on the practice of medicine. Outstanding lifestyle, excellent income guarantee, complete benefits and ownership eligibility. Call or send CV to Denis Albright, Medical Associates Clinic, 1000 Langworthy, Dubuque, Iowa 52001; 800/648-6868.

(Continued next page)

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Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Clarkson Family Medicine—Opened its doors to an excellent, totally remodeled facility on July 1, 1991. We are now preparing for our first graduation ceremony. Since our first class of residents, we have filled in the Match Program every year with high quality residents. Our patient numbers have exceeded our most optimistic projections, allowing us to consider expanding our resident numbers. An additional physician faculty and associate director are needed to assist us in expanding our program and services while continuing our commitment to the training of physicians for excellence in rural practice, including extensive OB experiences. Responsibilities include direct patient care, resident and student supervision and scholarly activities. Candidates must be board certified in family practice with a desire to participate in the growth of an exciting new program. Strong OB experience is highly desirable. Salary and benefits are extremely competitive and dependent upon experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants that use tobacco products. EOE. Serious applicants should send letter of inquiry and/or CV to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, Nebraska 68131.

Class A Medical Office Space—One physician office, on-hospital campus location. If interested, please call Tracy at 283-2217.

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Recruitment for Physician for Amb Care Service—Opportunity for BC/BE internal medicine physician for VA Emergency Room and Outpatient Clinics. Regular scheduled work hours. Des Moines VAMC is a 173-bed acute medical/surgical hospital with large multispecialty outpatient care area. Community-based residencies in internal medicine and general surgery affiliated with the University of Iowa offer opportunities for teaching residents and medical students. Opportunity to work on inpatient wards can be arranged. Starting compensation range from $86,000 to $98,000, with scheduled raises based on satisfactory performance, 4 weeks vacation and up to 2 weeks of educational leave. Des Moines combines the advantages of Midwestern small town family living with the cultural amenities of an urban center. This city is particularly noted for the excellence of its public and parochial school systems. Submit CV to Dr. Shelley Jones, ACOS-Amb Care, VAMC, 3600 30th Street, Des Moines, Iowa 50310-5774, 515/255-2173, extension 5663. EOE.

Council Bluffs, Iowa—BC/BE FP and IM physicians needed for expanding multispecialty group with modern facilities adjacent to 300-bed Mercy Hospital. Council Bluffs, population 55,000, has excellent schools and housing and is within easy access of wonderful cultural and recreational activities, including symphony, ballet, opera and water sports. Competitive compensation, full benefits and shareholder opportunity. Please call Steve McNeill now at 402/398-6658 or fax CV in complete confidence to Mercy Hospital, 402/398-6032.

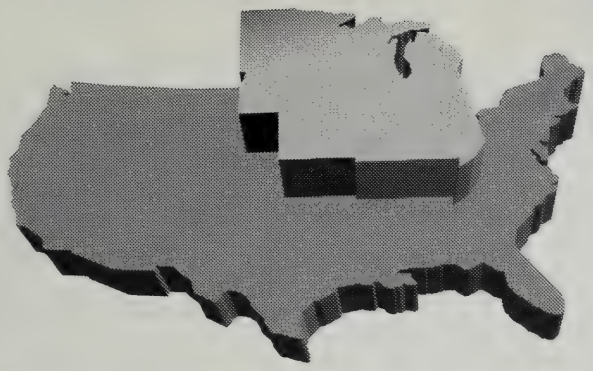
Council Bluffs, Iowa—BC/BE primary care physicians needed for ER group of 3 serving primarily urgent care patients. Excellent compensation and signing bonus and full benefits plus flexible schedule providing for one week off each month. Mercy Hospital, a 300-bed facility, has a modern ER and is physician friendly. Council Bluffs, population 55,000, has excellent schools and housing and is within easy access of wonderful cultural and recreational activities, including symphony, ballet, opera and water sports. Please call Steve McNeill immediately as this is a special opportunity, 402/398-6658 or fax CV in complete confidence to Mercy Hospital, 402/398-6032.

LeMars, Iowa

Seeking quality physicians to practice at a 4300 average volume ER. Director and staff positions. Full and regular part-time. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Omaha, Nebraska—BC/BE female FP sought for 3 physician FP group affiliated with Bergan Mercy Medical Center. Excellent position for physician seeking opportunity to practice quality medicine and be affiliated with physician friendly hospital. Competitive compensation, including signing bonus, and full benefits, including relocation. Enjoy the varied cultural and recreational activities of Omaha, affordable housing and excellent parochial and public schools. Please call Steve McNeill now at 402/398-6658 or fax CV in confidence to Bergan Mercy Medical Center, 402/398-6032.

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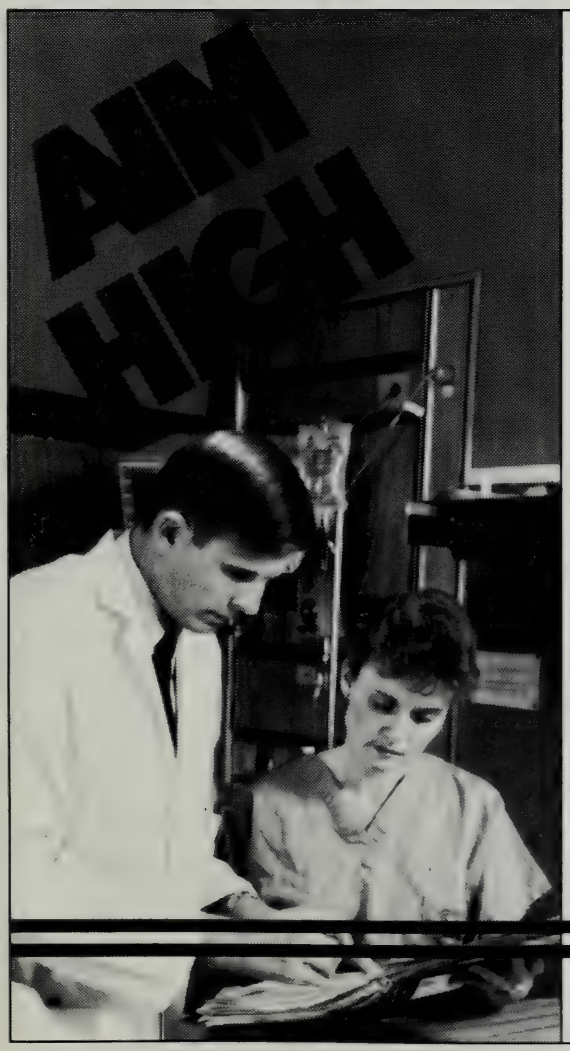
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Otolaryngology–Head and Neck Surgery, Facial Plastic Surgery, Allergy

Phillip A. Linquist, DO, PC
1000 Illinois
Des Moines 50314
515/244-5225
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Pain Management

Mercy Center for Pain Management
Randall L. Busch, MD, MS, DDS, Director
1890 John F. Kennedy Road
Dubuque 52002
319/556-7542
fax 319/556-8334

Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
600 7th Street SE
Cedar Rapids 52401
319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology

Des Moines Perinatal Center, PC
Neil T. Mandsager, MD
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
Maternal-Fetal Medicine
Routine and Advanced (Level II) Obstetric Ultrasound
Genetic Counseling
Amniocentesis and CVS
Antenatal Testing
High-Risk Obstetrical Management
High-Risk Deliveries

Physical Medicine & Rehabilitation

Rehabilitation Medicine Associates
William D. DeGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Younkers Rehabilitation Center
Iowa Methodist Medical Center
1200 Pleasant
Des Moines 50308
515/283-6434

Mercy's Regional Rehabilitation Center
Mercy Hospital
1401 West Central Park Avenue
Davenport 52804-1769
319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Pulmonary Medicine

Chest, Infectious Diseases & Critical Care Associates, PC
Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Ronald L. Rains, MD
Pulmonary Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hour 515/224-1777

Fort Dodge Medical Center, PC
Robert C. Ang, MD, FCCP
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Surgery

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Kirk D. Green, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Wendell Downing, MD
1212 Pleasant Street, Suite 410
Des Moines 50309
515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC
Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Urology

Fort Dodge Medical Center, PC
Leland M. Coffman, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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Momentous times for AMA

Delegates to the AMA experienced emotional debates and momentous times at the AMA annual meeting.

Your North Central Medical Conference, of which Iowa is a member, placed three of four candidates to AMA positions. Don Young of Iowa City—formerly of Des Moines—won a seat on the AMA Scientific Affairs Committee. Some have wondered why more offices are not challenged at the state level. I believe this is not because of the time commitment or difficulty of the job but is due to fear of losing.

The Iowa attendees, AMA delegates, alternate delegates and officers separated to attend eight committee hearings. I attended committee "F" which dealt with the AMA's finances and long-range planning. Your AMA is healthy and no dues increase was recommended. Last year's income was down compared to the previous year, primarily because of the decrease in pharmaceutical advertising in AMA publications. It is predicted this revenue won't be coming back and magazines may be replaced in the future by CD-ROM. Change continues and adjustments affect personnel. AMA trustees promise to search for new revenue sources.

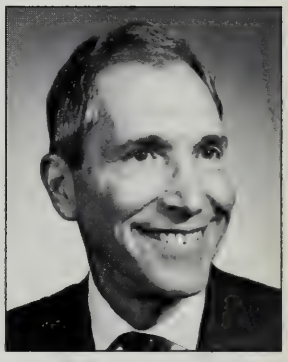
In the long-range planning area, a report on the county as a unit of membership was questioned by delegates. Can hospital staffs, large clinics and organized delivery systems be units of memberships? That report will be sent to all county medical societies.

Another committee concentrated more on health reform issues. Proposals to shun employer mandates sparked vigorous discussion. Delegates ended by reaffirming support for a flexible approach to achieving universal coverage. Delegates also gave the House more freedom to judge individual health reform plans in the context of AMA proposals.

Defining primary care would seem simple until a group of delegates tries to vote on it. AMA policy states that primary care is the provision of a broad range of medical care (prevention, diagnostic, curative, counseling and rehabilitation) in a manner that is comprehensive and coordinated by a physician over time. Care may be provided to an age or gender-specific group, as long as the care of the individual meets the above criteria.

This AMA proposal protects patients from arbitrary decisions.

"Patient Protection Act" rang through the halls of the Chicago Hilton Hotel, in the state medical officers' meeting preceding the House of Delegates, during the debates by the House of Delegates and in the past president's farewell speech. This AMA proposal protects patients and physicians from often arbitrary decisions made by for-profit managed care plans and insurance companies. Make sure you know what it says and that your lawmakers know, too. You can get a copy from your IMS staff. IM



James White, MD

IMS Update

AT A GLANCE

Michael Suk of Rockford, Ill. is the first medical student directly elected to the AMA Board of Trustees. In the past, student board members have been nominated by the Medical Student Section and then appointed to the AMA Board.

For more news from the AMA Annual Meeting, check out the Health System Reform *section of this issue and Dr. White's* President's Comments.

The AMA has decided to change the way it calculates physicians' incomes by averaging in wages of doctors employed by the government and those in training. Some physician delegates at the AMA Annual Meeting in June asked the AMA to stop issuing its reports on physician incomes. However, Dr. Nancy Dickey, AMA trustee, told the delegates the media would "publicize data from other sources".

FUTURES
Strategies for tomorrow's practice©

Have you heard about the Iowa Medical Society's Futures program? If you would like the latest information about your options in the managed care environment, this new IMS educational program is for you. Five regional meetings are scheduled in September and a statewide conference will be held October 27. Turn to the Health System Reform section (page 330) for all the details.

IMS Task Force on Domestic Violence

The IMS Task Force on Domestic Violence met in late July to formulate recommendations for the IMS Board of Trustees to consider at its August 10 meeting.

The task force, chaired by Dr. Rebecca Wiese, a Davenport family physician, is charged with developing recommendations to implement an educational program for physicians who treat victims of domestic violence. The IMS Alliance is represented on the committee.

Formation of the task force was approved by the IMS Board at its meeting in early May. Watch upcoming issues of *Iowa Medicine* for information about the task force activities.

AMA federation study underway

A study of the federation of organized medicine by a 200-member consortium has been launched by the AMA, with the initial meeting attracting representatives of county, state and specialty societies and other related organizations. John Rhodes, Jr., MD, a Pocahontas family physician, represents the IMS.

The AMA initiated the study in response to the changing health care environment, greater diversity of the physician population, increased pressures on resources and the need for unity of purpose in organized medicine.

According to Dr. Joseph Painter, AMA president, the objective is to "identify and pursue practical process and relationship changes that will enhance organized medicine's ability to serve physicians and patients."

Consortium members identified the following priorities the most important for the future of organized medicine: credibility and reliability in the eyes of the public; capability to respond to diversity among physicians; organization which engenders trust; stable financial base; and the ability to build strategic alliances.

District Councilor elections

Dr. William Bonney, a University of Iowa urologist, has been elected as councilor in IMS Councilor District II. Dr. Jay Heitsman, an Ottumwa pediatrician, has been elected as councilor in Councilor District IX.

Also, Dr. Kathryn Opheim, a Sioux City family physician, has been elected as the new chairman of the IMS Judicial Council.

Specialty Society Update

The Iowa Medical Group Management Association plans a legislative priority survey of its active members.

The Iowa Association of County Medical Examiners now has 75 members and plans an annual meeting October 28 in Ames.

The Iowa Psychiatric Society will participate in the Mental Illness Intervention Task Force mandated by the legislature and staffed by the attorney general's office. Paul Loeffelholz, MD and Dana Petrowsky, IPS executive director, will represent the IPS.

The Iowa Oncology Society met recently with representatives of the Department of Human Services and Unisys to discuss Title 19 reimbursement issues.

Focus on IMS Alliance

It was a privilege for me to represent Iowa as one of six delegates to the AMAA Convention in Chicago in June, and a special pleasure to attend the opening ceremonies of the AMA House of Delegates. Mary Hanson, our outgoing president, presented our $2,393,187 contribution to AMA/ERF and the Iowa Alliance received an award for the third highest increase in donations. Iowa also was one of nine states to see a membership increase; Linn and Polk Counties were specifically cited.

We are very proud to have Martha Holzworth, past IMSA president and member of the AMAA's AMA/ERF Committee, elected to the national Nominating Committee.

The IMSA introduced a resolution which changes the AMAA fiscal year to coincide with the AMA's. More counties could use a dual billing process and all membership drives could begin at the same time. This would bring us in line with the IMS for a more concerted membership effort. The resolution will be studied by a strategic planning committee.

"One Choice — One Voice" is the theme for the new AMAA President Barbara Tippins. In Iowa, we have great resolve to emphasize the need for unity, solidarity and a shared vision. The Alliance reaches out to communities and feels the pulse of the people. Working with the IMS, we can achieve unity as we work toward our common goals.

Contributed by Barbara Bell, IMSA president

Please return *Iowa Medicine* survey

In early July, a postcard survey was mailed to all IMS members regarding their readership of *Iowa Medicine*. The survey is being taken in preparation for the strategic planning process and was designed to help IMS leadership and staff evaluate the effectiveness of the communications plan. If you have not returned the postage-paid survey, please do so as soon as possible.

IMS staff changes

Dana Petrowsky has joined the staff of the Iowa Medical Society as manager of specialty services. Ms. Petrowsky will serve as the executive director for IMS specialty groups including the Iowa Psychiatric Society, the Iowa Medical Group Management Association, the Iowa Society of Rehabilitation Medicine, the Iowa Association of Long Term Care Facility Medical Directors, the American College of Cardiology (Iowa Chapter) and the Iowa Oncology Society.



Dana Petrowsky



Mary Reinsmoen



Barbara Cannon

Ms. Petrowsky comes to the IMS from Kansas City, where she served as regional director of the US Department of Health and Human Services as a member of the Bush administration. She replaces Mark Templeton, JD, who resigned to pursue a private law practice.

Also, Mary Reinsmoen has joined the IMS staff as practice management coordinator. Ms. Reinsmoen has been an elementary teacher with Des Moines Public Schools and is former office manager for Des Moines Internists, PC.

Barbara Cannon has assumed the position of director of medical economics for the IMS. She was IMS director of practice management. Prior to joining the IMS staff three years ago, Ms. Cannon was director of Medicare Part B for Blue Cross Blue Shield of Iowa.

The staff reorganization was due to the departure of Tim Gibson, IMS vice president of policy and programs, who accepted a position with the John Deere Health Plan.

Hawkeye Science Fair winners

Ten Iowa students placed in the International Science Fair competition. The students competed first at the Hawkeye Science Fair held every April in Des Moines. The event is cosponsored by the Iowa Medical Society, the Des Moines Register, Merle Hay Mall and Drake University. IM

AMA initiated the study in response to the changing health care environment.

Health System Reform

Have you planned for the future?

If you don't have a clear answer to this question, you can benefit from the Iowa Medical Sociey's new ***Futures*** program. ***Futures***, which will be launched next month, is a comprehensive effort by the IMS to help physicians explore their options and formulate a viable plan for the future of their practices.

The ***Futures*** initiative will begin with five regional programs around Iowa in September (see schedule below); the next step will be a statewide day-long ***Futures*** conference Thursday, October 27 in Des Moines.

> ***Futures*** PROGRAM SCHEDULE
>
> **"Organizing for the Future" regional meetings:**
> • **STORM LAKE** — Monday, September 19, 7:00 pm, Buena Vista College.
> • **MARSHALLTOWN** — Thursday, September 22, 7:00 pm, Marshalltown Medical Center.
> • **DUBUQUE** — Tuesday, September 27, 7:00 pm, Dubuque Inn.
> • **BURLINGTON** — Wednesday, September 28, 7:00 pm, Pizazz Best Western.
> • **ATLANTIC** — Thursday,September 29, 7:00 pm, Atlantic Country Club.
>
> **"Organizing for the Future" statewide conference:** Thursday, October 27, 8:30 a.m. — 4:30 p.m., Marriott Hotel, Des Moines.

The purpose of the regional programs is to gather input from Iowa physicians which will help determine the content of the statewide conference and other IMS programs. These programs will be held in the evening and will be about two hours long. They will begin with a slide presentation discussing physicians' options in the managed care environment and the need to plan for the future. Following the slide presentation, physicians should be prepared to discuss their concerns.

The statewide conference, **"Organizing for the Future"**, will feature nationally known consultants who will discuss medical practice options, contracting advice, capitation calculations, working with professional assistants and other key issues. Dr. James Todd, executive vice president of the American Medical Association, will be the luncheon speaker.

On the evening of October 26, IMS leadership will meet with representatives of specialty societies and large county societies to discuss the ***Futures*** program and medical practice issues. Dr. Todd will also address this group.

IMS staff are working on a number of educational materials which will be available at the statewide conference. These will include detailed information on planning for the future, how to hire and work with a consultant, various practice models such as the Physician Organization and other topics.

Watch the September and October *Iowa Medicine* for a registration form for the statewide conference "Organizing for the Future".

AT A GLANCE

A recent national survey by a large Boston HMO found that consumers choosing a health plan rank quality measurements the lowest in importance among five categories of information. Consumers prefer information on which doctors belong to the plan. The findings may be a reality check for groups pushing to provide consumers with report cards on quality of care.

The latest word in the health care debate is 'trigger'. The trigger strategy is a way to see if voluntary measures alone will work to lower the number of uninsured and reduce costs before imposing federal mandates. Some view the strategy as a bridge between those who favor market reforms and the Clinton plan premise that stronger medicine is needed.

Lively discussion at AMA meeting

An Iowa delegate was one of many physicians testifying at a lengthy and, at times, heated reference committee hearing at the AMA Annual Meeting.

The lively debate, held in the packed ballroom of the Chicago Hilton, was sparked by an AMA Board of Trustees report in support of a limited employer mandate and a resolution which asked the AMA to express formal opposition to the Clinton reform plan.

The most strenuous opposition to employer mandates and the Clinton plan was expressed by physician delegates from Texas, Illinois, Georgia and Pennsylvania. Delegates from Minnesota, Oregon, New York, Washington,

WORTH REPEATING

"I don't think lawmakers are hearing people say 'Don't do anything', I think they're hearing people say, 'Fix the problem but don't turn the world upside down'."

John Rother, legislative director of the American Association of Retired Persons.

Massachusetts and others urged a more middle-of-the-road approach.

Dr. Bruce Trimble of Mason City was one of those testifying.

"There are no pure financing mechanisms for health system reform. Any plan will blend a variety of mechanisms, so it's appropriate for the AMA to have a plan that blends mechanisms," he commented. "We shouldn't take rhetorical positions."

A physician from the Chicago Medical Society cited a proverb which allegedly warns "the guy in the middle of the road gets run over from two directions", but other physicians said the AMA Board has put physicians in a politically advantageous position.

"The AMA hasn't done this by being negative," said one physician. "Let's not aim our heavy ammunition at something that's going to die on its own."

Several physicians who said they are practicing "under the tyranny of managed care" urged the AMA not to discard a single payer system as an option, but this point of view found little support among delegates.

Based on the report from this reference committee, the full House of Delegates later voted to stay the course the AMA set out at its interim meeting last December. This approach, as summarized by Dr. Trimble, favors a variety of mechanisms — including an employer mandate — for achieving universal coverage.

Patient Protection Act gains support

As the AMA stepped up a public advertising campaign involving the Patient Protection Act, the proposal was gaining sponsors. The bill's two original sponsors are Senators Paul Wellstone (D-Minn.) and Conrad Burns (R-Mont.) As of press time, the Act had garnered seven House sponsors.

Also, AMA lobbying successfully accomplished inclusion of large portions of the Patient Protection Act in the health system reform bill marked up by the House Education and Labor Committee.

AMA advertising is designed to explain the PPA to the public and dispel criticism that it is an "any willing provider bill". The AMA ads state that "once again, the insurance industry is trying to pull the wool over your eyes" because they are "afraid of other things this bill contains".

Meanwhile, the Iowa Medical Society has sent a fax broadcast to all its legislative contact physicians urging them to send messages to Congress in support of the Patient Protection Act. The five major congressional committees with jurisdiction over reform will probably complete floor action by the end of this month and go to conference committee enactment in September and October.

All IMS physicians are urged to write to their representatives and senators in support of the PPA. The PPA would ensure that:

- patients and their physicians control the care patients get, not insurance companies;
- patients have a choice of physicians and health plans;
- patients have information about what their plan covers, copayments and prior approval requirements;
- physicians cannot be kicked out of a plan for giving patients the care they need;
- patients who choose a plan that restricts access to physicians may purchase a point-of-service option to see an outside physician.

Call Chris Clark at the IMS (515/223-1401 or 800/747-3070) for copies of the AMA's "Patient Protection Act: Questions and Answers".

"There are no pure financing mechanisms for health system reform."

Centrist bill from 'Chafee group'

Senate Finance Committee Chairman Daniel Moynihan (D-NY) has marked up what could prove to be a viable health system reform bill which is being credited to the 'Chafee group'.

Working with a bi-partisan group of so-called centrists, Senator John Chafee (R-RI) has reportedly engineered a consensus package to which Moynihan has given the nod.

The Chafee group's package was expected to include the following elements:

- A package of fundamental insurance reforms.
- No employer mandate, but some sort of employer tax.
- A universal coverage target of 97% by the year 2001.
- An individual mandate triggered within five years of enactment if universal coverage is not otherwise achieved.
- A commission to study the progress toward broader coverage and make recommendations including the components of a benefit package.
- $60 billion in Medicare cuts (this figure could include Medicaid).

continued

Health System Reform

continued

•A 60-cent cigarette tax increase.
•A tax on expensive health care plans.

According to the *Wall Street Journal*, the White House has been giving "quiet encouragement" to the Chafee group.

Health care polls perplexing

Congress is reportedly confused about public opinion on containing health care costs and polls are adding to the confusion.

"Polls show Americans saying, 'One, lower my premiums. Two, cover the uninsured. Three, solve the cost problem'," said Robert Blendon of the Harvard School of Public Health. "Pollsters think that slowing national spending is the same as lowering your Blue Cross premiums. It isn't the same at all."

When polls present people with the basics of cost containment (raising deductibles, capping total spending of limiting tax-deductibility of insurance) nearly 50% say no. Yet, polls show broad support for cost containment.

Study on physician health insurance

The AMA calls "unfounded" assertions by several major newspapers that physicians do no better — and possibly worse — than business when it comes to providing health insurance for their workers.

The AMA Center for Health Policy Research data show that employees in medical practices may be three times more likely to be offered health insurance benefits than their counterparts in the general workforce.

There have been charges from some groups that AMA opposition to employer mandates stem from self-serving interests of physicians who don't want to pay for insurance for their own employees, and this subject came up in a reference committee hearing during the AMA Annual Meeting. One AMA delegate who testified in opposition to general employer mandates said he would be "happy to have a mandate that every doctor pay for employees' health insurance, if that would clear the air." IM

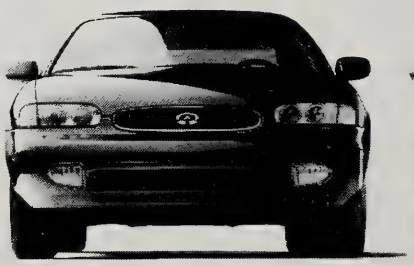
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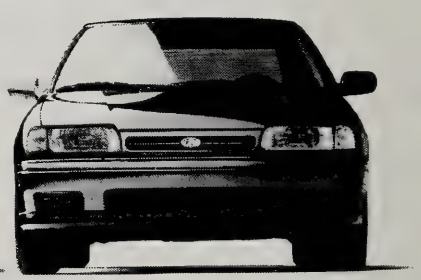
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Legislative Affairs

New laws effective July 1

The following new laws affecting physician practices went into effect July 1.

Medicaid reimbursement increases

Physicians will receive a 10% increase in reimbursement for obstetrical services and a 5% increase for Early and Period Screening, Diagnosis and Treatment (EPSDT) services provided to Medicaid patients. No increases are provided for other physician services.

Telemedicine

Physicians and hospitals are authorized to use the state fiber optic network for telemedicine purposes. Procedures for linking up, costs of using the network and other operational details remain to be developed.

Rural health

The Iowa Department of Public Health is required to establish area health education centers (AHECs) in cooperation with the University of Iowa College of Medicine, the University of Osteopathic Medicine and Health Sciences and other educational institutions. This requirement is contingent on receiving funding from the federal government.

HIV notification

State and county medical examiners and deputies are now allowed to notify immediate family members and partners of a deceased person that the deceased person tested positive for HIV. This may only be done as part of the medical examiners' official duties.

Nurse practitioner prescribing

Beginning July 1, nurse practitioners, including nurse anesthetists, are allowed to prescribe both controlled and noncontrolled substances under rules of the Board of Nursing developed in consultation with the Board of Medical Examiners and the Board of Pharmacy Examiners. Before July 1, nurse practitioners could prescribe noncontrolled substances only and nurse anesthetists could not prescribe.

Contact lens prescriptions

Opthalmologists and optometrists must provide a copy of a prescription for contact lenses to a patient after fitting and follow-up care. However, contact lenses may be dispensed by a person who possesses a written prescription.

Other new laws

Health insurance

Beginning January 1, 1995 employers will be required to offer their employees access to health insurance benefits, although the employer will not have to pay for those benefits. The insurance commissioner will adopt rules to implement this new requirement.

Electronic claims processing

No later than July 1, 1996 physicians, hospitals and other health care providers will be required to submit health insurance claims electronically using a standard claim format. Payors will be required to accept electronically filed claims. The Community Health Management Information System (CHMIS) board will adopt rules to implement this requirement including provisions for strict confidentiality of patient and provider information.

For copies of the new laws call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

Organized delivery systems

The Iowa Department of Public Health has developed rules governing "organized delivery systems" including accountable health plans. Rules have been filed for immediate implementation but will also go through the normal rulemaking process with opportunity for public comment. Written comments may be sent to Barb Nervig, Iowa Department of Public Health (IDPH), Lucas State Office Building, Des Moines, Iowa 50319-0075.

A public hearing with be held August 17, 1994 from 8:15 to 11:00 a.m. using the Iowa

continued

AT A GLANCE

Watch next month's Legislative Affairs section for an interview with Dr. Greg Ganske, who is making a bid for 4th District congressional seat held by Neal Smith.

Application packets are available for the Volunteer Physician Program established in May of this year. Any physician or eligible program should contact Cheryl Christie, Iowa Department of Public Health, 515/281-6645.

The IMS has available to members a videotape of a Medical Examiners Seminar sponsored by the IMS and the U of I. It includes presentations by Thomas Bennett, MD, state medical examiner, and other experts. Call Lyn Durante or Becky Roorda at the IMS for details on borrowing or purchasing the set.

Legislative Affairs

continued

Communications Network (state fiber optic network). Oral comments may be made at the following locations:

Western Iowa Tech Community College, BLDG D, Room 126, Sioux City; **Iowa Western Community College,** Lee DeForest Hall, Room B145, Council Bluffs; **North Iowa Area Community College,** Activity Center, Room 106, Mason City; **Kirkwood Community College,** Linn Hall, Room 202, Cedar Rapids; **Iowa Public Television,** Johnston.

An organized delivery system (ODS) is defined as "an organization that is responsible for delivering the full range of health care services covered under a standard benefit plan and is accountable to the public for the cost, quality and access of its services and for the effect of its services on their health."

An ODS may not operate in Iowa without approval by the IDPH although other delivery systems may operate without such approval.

An ODS will receive the advantage of some protection from antitrust action under both state and federal law. This is possible through the state action exemption which provides some protection to cooperative provider arrangements which are likely to result in lower costs, greater access or improved quality than would otherwise occur in the marketplace.

Rules contain these provisions:

Service area

An ODS may choose its own service area subject to approval by the department. Market areas must use counties as indivisible units. Within the geographic service area, primary care must be available within the lesser of 30 minutes travel time or 30 road miles. Primary inpatient hospital care must be available within 60 minutes travel time. Secondary and tertiary care may be provided outside the service area.

Enrollee participation

There must be enrollee representation on the governing body and an enrollee advisory committee.

Provider network

Each ODS has flexibility to establish a provider network to achieve the balance of providers which best meets the needs of its enrollees. An ODS may determine its credentialing standards and criteria for inclusion in the network. The standards and criteria shall be public and the ODS must follow them. An internal provider appeal process must be established. Data must be provided to the IDPH on the utilization of providers by type of provider.

Emergency services

Emergency services must be provided 24 hours a day, either through ODS providers or through arrangements with others. ODSs must inform enrollees of participating emergency providers.

Accountability

Each ODS is required to provide information to the IDPH on measures of quality, access, member satisfaction, membership and utilization, finance and management. Indicators will be determined by the department based on nationally recognized standards.

There are many other requirements in the rules. For a copy, contact Becky Roorda at the IMS, 800/747-3070 or 515/223-1401.

The Vaccine For Children program is intended to reduce the need for providers to refer children to public clinics for vaccination.

Vaccine For Children program

Beginning October 1, the Iowa Department of Public Health (IDPH) will offer free vaccine to private medical providers. Vaccine For Children (VFC) is a new entitlement program intended to raise childhood immunization levels.

Vaccines provided by the federal government will be available free to private and public providers for eligible children from birth through age 18 who are enrolled in Medicaid, without health insurance or children who are native American Indian or Alaskan.

Children whose insurance does not include immunizations as a benefit may receive free vaccine from a federally qualified health center, rural health clinic or public clinic.

The provider's responsibilities are to complete a provider enrollment form, complete an annual provider profile form, screen and maintain eligibility records for VFC eligible children and provide vaccine at no charge to VFC eligible children while limiting administration fees according to established fee caps.

The IDPH will have 800 numbers available for physicians and will have an 800 number fax line physicians can use to order vaccines. The IDPH will provide vaccine information statements to all providers enrolled in the program.

VFC goals are to enable private health care providers or parents to save about $270 per child in out-of-pocket expenses and reduce the need for providers to refer children to public clinics for vaccination. IM

Medical Economics

Medicaid managed mental health care

The Department of Human Services (DHS) has awarded a $102.4 million contract to a Virginia firm to manage the psychiatric care provided to Iowa Medicaid patients. Value Behavioral Health, Inc. (VBH) of Falls Church, Virginia won the two-year contract from among eight bidders.

However, as of press time it was learned that DHS is being sued by an unsuccessful bidder. This could postpone the implementation date of the contract, which was set for September 1.

VBH — which manages mental health benefits for 156,000 Iowans through private company contracts — will also provide for the mental health needs of approximately 190,000 Medicaid recipients. VBH was chosen for its demonstrated understanding of the Medicaid population, strong consumer orientation, a good approach to increasing access to mental health in rural areas and a strong collegial approach to working with Iowa's mental health providers.

The Value Behavioral Health Company provides mental health and substance abuse managed care services in all 50 states.

Iowa is the first state to manage their Medicaid mental health services statewide.

Single Medicare payment locality

In late June, the *Federal Register* published a notice of a proposed rule describing a proposal by the Health Care Financing Administration (HCFA) to designate Iowa as a single Medicare payment locality.

Iowa's request to be granted single payment status was sent to HCFA in February of this year, and HCFA determined the IMS had provided sufficient proof that a majority of physicians favor the move.

In order for the measure to be implemented, Iowa physicians must indicate support for this proposal. In the absence of adequate support from physicians, the proposal could be denied.

Publication of the HCFA proposal in the *Federal Register* and solicitation of comments from physicians is the standard procedure for single locality requests.

The IMS first sought single payment designation in 1992 at the request of a significant number of practicing physicians. This request was denied before it got to the publication phase because it was not unanimously supported in all areas of Iowa. Then, in 1993, opposition from the University of Iowa College of Medicine Faculty Practice Plan was withdrawn.

The IMS supports the plan because it could help attract physicians to rural Iowa. Based on House of Delegates directives, IMS urges physicians to register support for the single payment locality by returning a postcard which was mailed to practicing physicians in July. HCFA must receive your comments by August 24.

IMS represented on CHMIS Board

Iowa physicians will be represented on the governing board for the Community Health Management Information System (CHMIS).

CHMIS — generally accepted as the information component of health system reform in Iowa — will allow health care providers to submit claims electronically and receive reimbursement electronically. Data from these encounters can be stored in a central repository.

Phase one of the data repository will involve information collected from the HCFA 1500 claim form and the UB 92 facility claim form. Decisions have yet to be made regarding confidentiality implications connected with further uses of the data repository. Iowa physicians will be involved in this process.

The Iowa Insurance Department will oversee a CHMIS governing board which has now been appointed by the Governor. The governing board includes two Iowa physicians — Dale Andringa, MD, Des Moines and Beth Bruening, MD, Sioux City. The board also includes two hospital

continued

AT A GLANCE

A rising percentage of doctors have agreed not to bill Medicare patients for more than the charges approved by the federal program, according to the Associated Press. The Health Care Financing Administration says a record 65% of physicians have agreed this year to accept Medicare's fee schedule as full payment.

The Iowa Health Data Commission has developed a study entitled "A Model to Predict Medical Resource Consumption: Coronary Artery Bypass Draft Procedure". The study, written by Kathryn Goldberg, Ph.D., identifies the inadequacy of Diagnostic Related Group (DRG) classifications for determining illness severity. For copies of the study, call Donna Bottorff at the IMS, 515/223-1401 or 800/747-3070.

Medical Economics

continued

administrators, two insurance company representatives and five consumers.

The CHMIS network will link health care providers, purchasers, payers and patients to an integrated system. This system will: 1) integrate hardware and software systems of the participants; 2) provide for extensive eligibility, utilization review, encounter and claims processing support; 3) deliver remittance advisories from payers to providers; 4) accommodate credit and debit card billing for non-covered balances; 5) acquire and maintain demographic financial employment, insurance and encounter data; 6) create reports for providers, purchasers and patients; 7) monitor and periodically report to the community on its wellness and health care delivery.

The CHMIS network will link health care providers, purchasers, payers and patients.

The Iowa Medical Society's CHMIS Committee is still in existence and will meet August 22 to discuss strategy for educating IMS physician members and maintaining ongoing involvement in developing the CHMIS system.

CLIA billings sent

The Health Care Financing Administration (HCFA) has issued the second two-year renewal billings for the various categories within the CLIA program. In the first week of July, billings for this two-year renewal period were sent to physician office laboratories in the: 1) Certificate of Waiver Category; 2) Certificate of Physician Performed Microscopy Category; and 3) Moderate and High Volume Categories.

HCFA will bill the laboratories with a certificate of accreditation. However, those bills have not been released. The two accrediting organizations authorized by HCFA are the College of American Pathology (CAP) and the College of Laboratory Accreditation (COLA). The expected fees for the various categories are: $100 for the Waiver Category; $150 for the Physician Performed Microscopy Category and approximately $300 - $3,000 for laboratories operating in the moderate to high category. This billing is based on the volume of tests provided in the individual laboratories.

Laboratories have 30 days to send payment. All first year certificates expire August 31, 1994. HCFA has identified Iowa physician offices operating labs without a CLIA certification; termination of these labs is being discussed.

For questions concerning registration and renewal billings, contact Nancy Ruzicka at the Department of Inspections and Appeals, Des

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Moines, Iowa 515/285-4120. The CLIA hotline number is 410/290-5850. When you call the CLIA hotline, have your CLIA 10-digit certificate number available.

Physician office laboratory inspections are continuing in Iowa. State hygienic lab personnel are performing approximately 25-30 laboratory inspections per month.

HCFA releases DEMPAQ study

According to the results of a study released July 13 by HCFA, there are problems relying on Medicare claims and medical records as tools to improve the quality of care given to Medicare beneficiaries.

In the fall of 1990, 53 Iowa physicians, the Iowa Foundation for Medical Care and the Harvard School of Public Health initiated a study which used Medicare claims and physician office records to evaluate the quality of care given to Medicare beneficiaries in primary care physician offices.

Following a five-step process, profiles were developed for patients with diabetes, hypertension, congestive heart failure, aphemic heart disease, chronic obstructive pulmonary disease and osteoarthritis. Performance measures were developed for each condition.

The reasons Medicare claims and medical records are not reliable tools in evaluating quality of care are difficulty reading physicians' handwriting, variability in documentation levels and the fact that the study criteria was too stringent.

The full report will be mailed to the Iowa Medical Society in the near future. For more information, call Donna Bottorff at the IMS, 515/223-1401or toll-free 800/747-3070.

Medicaid funding and EPSDT

As a result of OBRA '89 legislation, states are required to demonstrate that 80% of the Medicaid recipients under the age of 21 are receiving Early Periodic Screening Diagnosis and Treatment (EPSDT) screens according to the American Academy of Pediatrics Periodicity Schedule. This schedule is found in the Medicaid provider manual, chapter E, pages 6 and 7.

The goal is 80% screens for EPSDT Medicaid recipients by fiscal year 1995.

Iowa's rate continues to increase, but significant progress will be required to reach the goal. Overall Medicaid funding will be jeopardized if this 80% goal is not attained.

The Health Care Financing Administration (HCFA) has not allowed well-child CPT codes to be used in meeting the 80% goal. If all components of an EPDST are met, physicians should use the screening code W0051. In many cases, a simple change in how you bill for services will give a more accurate picture of how many children are using this important service.

Because Medicaid funding could be in jeopardy, the Department of Human Services is considering implementation of a policy that all well-child visits shall meet all EPSDT components and be billed as a screen using code W0051.

The current reimbursement level for the procedure code W0051 is $39. The reimbursement for a well-child check using the standard evaluation and management code is $25.

The Iowa Medical Society is collecting input from various provider sources regarding this proposed policy. If there are no demonstrated problems using code W0051 100% of the time, this policy will be in effect August 1, 1994.

Physicians who treat children covered under Medicaid would be required to provide all components of an early periodic screening, diagnosis and treatment screen and bill the services using the screen code W0051 on the HCFA 1500.

A complete EPSDT Care for Kids screening has four components — basic screening, dental services, vision services and hearing services.

As part of the basic screening, providers would:

- gather a complete health and developmental history, including physical and mental health;
- perform a complete, unclothed physical examination;
- review immunization status for age and health history;
- arrange for appropriate lab tests; and
- provide age-appropriate health education, including anticipatory guidance.

For additional questions concerning the EPSDT program, please contact Donna Bottorff at the IMS. IMS telephone numbers are 515/223-1401 or toll-free 800/747-3070. IM

Medicare claims and medical records are not reliable tools in evaluating quality of care.

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Practice Management

AMA releases CPT 'errata'

The American Medical Association has released a 1994 CPT Errata which corrects errors in the 1994 CPT Code Book.

Some of the errors in the CPT Code Book, listed by page number, are:

Page 26 in Clinical Supplements — The heading for code 99243 was deleted. The last two clinical vignettes of code 99242 are actually the vignettes for code 99243.

Page 51 — In the Neonatal Intensive Care opening statement, paragraph two gives the additional codes to use as 99354, 99357 and 99440. The correct codes are 99356, 99357, 99360 and 99440.

Page 199 — Code 27760 is a parenthetic which states that (27760 has been deleted. To report, see 27762, 27766). Code 27760 is a valid code. The parenthetical instruction should not have been printed.

Page 258 — In the parens following code 35700, the code 35566 was left out. This code should be listed following code 35556.

Page 285 — The parenthetical instruction under code 43259 says (For radiologic supervision and interpretation, see 76936). It should read "see 76975".

Page 302 — Second stage anal fistual treatment should be indented under 46270. The code 46281 is valid but is not a parent code.

Page 362 — Under the Cesarean Delivery heading, the parenthetic states "For standby attendance for infant, see 99150, 99151". Codes 99150 and 99151 have been deleted. The correct code to use is 99360.

Page 448 — In the parens, the last code listed is code 75527. This is incorrect as code 75527 has been deleted. The correct code is 93555.

Page 472 — Code 74420 should read 77420.

Page 510 — The parenthetic above code 82331 says (82331 has been deleted. To report, use 82310). 82331 is a valid code, the parenthetical instruction should not have been printed.

Page 531 — The parenthetical states (84175 has been deleted. To report, use 84155). The code to use should be 84165.

Page 588 — In the third paragraph from the top, last line, the new CPT code 90842 should be added to that series of codes that may be used.

Page 607 — Code 93017 was omitted, however, it is a valid code, reading "tracing only, without interpretation and report" (indent to cardiovascular stress test).

Page 843 — In the index under ultrasound, spine, the code 76880 is given. The correct code is 76800.

continued

The IMS has a new practice management coordinator named Mary Reinsmoen; Barbara Cannon has assumed the position of director of medical economics. For details, see this month's* IMS Update *section, page 328.

AT A GLANCE

This month's IMGMA Newsletter *contains an impressive list of advantages to electronic medical records. A few of the advantages cited are: coding data accuracy, no lost charts, no legibility problems, built-in practice guidelines, improved record access and the ability to do practice analysis.*

Have you solved the problem of helping staff keep track of all the insurance companies? One Iowa clinic manager recommends color coding. On the front of each patient chart, place a colored label. Each insurance company is assigned a different color. At every nurses' station, keep a colored folder to match each label. These folders contain referral telephone numbers, a list of referral doctors and available hospitals.

Upcoming Workshops for You and Your Practice

Medical Terminology	August 10	Sioux City
Office Team Skills	August 12	Ft. Madison
Office Safety/Compliance	August 17	Cedar Rapids
Retirement Planning	August 18	Davenport
CPT Coding	September 13	West Des Moines
ICD 9 Coding	September 14	West Des Moines
Retirement Planning	September 15	West Des Moines

The popular physician/spouse retirement program "Plan Ahead for Financial Security" has been scheduled for Sept. 27 in Council Bluffs; Oct. 6 in Cedar Rapids; and Oct. 25 in Mason City. Contact Sherry Johnson at the IMS for details, 515/223-1401 or 800/747-3070.

Practice Management

continued

Ideally, clinic medical records should be retained permanently.

Midwest Medical Insurance Company Focus on Risk Management

Retaining medical records

An important aspect of medical records management is retention. Iowa law does not require health care providers to retain medical records for any specific time period. However, clinics must consider a variety of other factors when developing a policy on record retention.

Malpractice liability is just one of the many factors that must be considered. Clinics should be guided by the statute of limitations which determines the period of time following an incident in which legal action must be taken. For medical malpractice, the statute is two years after the date on which the patient knew or should have known of the injury or death for which damages are sought. In no event can action be brought more than six years after the occurrence unless a foreign object, unintentionally left in the body, caused the injury or death. A **minimum** logical period for retaining most patient records would then be seven years **from the last contact with the patient.**

The statute of limitations is extended in favor of minors. Records should ordinarily be retained until their 20th birthday or seven years from the last contact, whichever is longer. The statute is also extended for mentally ill or incompetent persons. MMIC and/or legal counsel should be consulted before these records are destroyed.

Ideally, clinic medical records should be retained permanently. However, if it is necessary to destroy medical records, basic information should be retained identifying the records that were destroyed. The clinic's corporate counsel, financial advisor and third party payors should also be consulted for advice on other considerations for retaining medical records.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

(The Iowa Medical Society has available a document entitled *"Physician's Guide to Release and Retention of Medical Records"*. Call Sheryal Westbrook at the IMS, 515/223-1401 or 800/747-3070 to purchase a copy.)

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Stephen Elliott, D.O. ..... Department of Pediatrics, Mercy Hospital Medical Center, Blank Children's Hospital, Des Moines, Iowa	**Hematologic Emergencies in Children**
Richard Nelson, M.D. ..... Department of Pediatrics, Division of Child Health Specialty Clinics, University of Iowa Hospitals/Clinics, Iowa City, Iowa	**Pediatric Disabilities: New Perspectives**
Melodee Hanes, J.D. ..... Office of the County Attorney, Polk County Courthouse, Des Moines, Iowa	**The Physician's Responsibility/Liability in the Abused Child**

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Newsmakers

Diversion of opiates for illicit use

Dear Editor:

Physicians are being subjected to an ever increasing media barrage, both lay and professional, instructing us to prescribe more opiates. As medical director of a methadone clinic I see the results: an ever increasing number of opiate addicts. While heroin may be the drug of choice for most opiate addicts, all have used pharmaceuticals intermittently and some exclusively. They get these pharmaceuticals from doctors (scam), pharmacies (rob) and patients (buy).

Letter to the Editor

I hear the stories over and over: "My source died, doc; you've got to help me."

Cancer patients can have severe pain. Hospice promises to eradicate that pain. Bills mount. Street prices range to $1.00/mg for MS Contin to $10.00/mg for Dilaudid. Supply and demand works its inevitable connection.

Especially Dilaudid, but also the morphine preparations, including MS Contin, are soluble and thus attractive for IV use. When needles are shared, the spread of HIV and hepatitis is another concern.

I have seen examples where patients have been given prescriptions for 100 and even 200 tablets of various opiates. Treating pain is an important consideration, but equally important is exercising reasonable caution to minimize diversion of opiates for illicit use.—*Dan Murphy, MD, Cedar Falls.*

Awards, appointments, etc.

The following physicians have joined Medical Associates in Dubuque: **Laurie Garms, MD, John Stecker, MD, Margaret Mulderig, MD** and **David Houlihan, MD.** Dr. Garms is in the Neurology Dapartment and Drs. Stecker, Mulderig and Houlihan are in the Psychiatry Department. **Dr. Barry Blyton,** radiation oncologist, has joined **Dr. Thomas Lally** in his Dubuque practice. **Dr. Nicholas Galioto,** Des Moines, has been appointed associate director of the Broadlawns Medical Center Family Practice Residency Program. Physicians in the Quad Cities and Mississippi Valley Regional Blood Center recently teamed up to help dispel the myth that HIV can be contracted via blood transfusions. **Jim Koch,** executive vice president of Scott County Medical Society explains: "Our members understood the reality that AIDS was not being transmitted via blood donation and set out to prove it by hosting their own blood Drive. It certainly succeeded; physician after physician came forward and rolled up his or her sleeve and gave." Mayo Clinic, Rochester, Minnesota, has affiliated with Medical Associates, P.C., a four-physician family practice clinic in New Hampton. The clinic will be named New Hampton Clinic—A Mayo Regional Practice. Ottumwa Regional Health Center has opened a new outpatient and industrial rehabilitation center. **Dr. William Eversmann,** Cedar Rapids orthopedic/hand surgeon, has been named by Governor Terry Branstad to a new 15-member panel which will advise state government on health care reform issues. Representatives of business, labor and health care are included on this Health Reform Transition Team. **Dr. Donald Young,** Iowa City radiologist and AMA delegate since 1982, has been elected to the AMA Council on Scientific Affairs. The Council provides physicians with scientific guidance on medical procedures and techniques most valuable to medical practice.

Correction

The July issue of *Iowa Medicine* incorrectly stated **Dr. Rosalie Neligh** as a deceased IMS member, when in fact, Dr Neligh's husband, **Dr. Gordon Neligh,** recently died. The editors regret the error. IM

AT A GLANCE

***Dr. Robert Kelch** has been named the new dean of the UI College of Medicine. Dr. Kelch is professor and chairman of the Department of Pediatrics at the University of Michigan School of Medicine and physician in chief at the C.S. Mott Children's Hospital. He has been a faculty member there since 1972 and recently served as assistant dean for clinical affairs and as chief of clinical affairs at the University of Michigan Hospitals.*

*The University of Iowa recently announced the receipt of a major gift from **Dorothy, Harry, Marvin** and **Rose Lee Pomerants** to the UI Hospitals and Clinics. The $3 million donation will be devoted toward the construction of the Pomerantz Family Pavilion. The Pavilion is the capstone to a $500 million, 20-year capital replacement program. Marvin Pomerantz was president of the Iowa State Board of Regents during the period when much of this capital program was undertaken.*

Responsibility and *JUSTICE* ... an ethical balance

Decisions about allocation of medical care involve weighing the needs of the individual and the needs of society. In this author's opinion, society has a right to expect that responsibility for one's illness be the primary focus when considering who receives scarce resources such as organs.

In this era of close scrutiny of our health care system, finding a more controversial program than liver transplantation in alcoholic patients may be difficult. This issue pits another expensive "medical rescue" for end-stage disease against a growing unwillingness to ascribe certain harmful behaviors solely to one's disease, beyond any degree of self-control.

On one side are concerns about fair and just use of available but often limited resources; on the other, an expectation to accept responsibility for one's actions. These themes—justice and responsibility—are fundamental to the debate over the future direction of our health care system.

Not surprisingly, justice and responsibility are also central issues in weighing the merit of performing liver transplants for alcoholic patients at the University of Iowa Hospitals and Clinics (UIHC). On both accounts, this program is not in the best interests of medicine or the public.

Distributive justice — equitable allocation of society's resources — applies to our health care system at many levels. Distributive justice is involved in consideration of how much of our federal budget to devote to health care as opposed to services such as education, housing, transportation and sanitation which promote public welfare. It is also the basis for determining the best use of specific limited resources such as ICU beds, promising drugs for AIDS or donated livers.

The needs of the individual are commonly juxtaposed against those of the community, state or nation. Our institutions and governments are responsible for ensuring the necessary balance between individual self-interest and the public good. A sense of justice provides the guidance in fulfilling this responsibility.

Appropriate use of resources is an obligation the institution assumes in return for public support.

The UIHC, the predominant influence on health care in the state, is responsible for addressing the health needs of Iowans. Appropriate utilization of resources, limited or not, is an obligation the institution assumes in return for public support of its programs. The intense concentration of dollars, technology and



CURTIS REYNOLDS, MD
Dr. Reynolds is a Cedar Rapids family physician. He teaches ethics and is the director of the Cedar Rapids Family Practice Medical Education Program.

HERE'S TO YOUR Health

A patient's guide to better health
Provided by the Iowa Medical Society

Vaccinations
information for children and adults

What is a vaccine?

A *vaccination* or *immunization* is a medicine given to help prevent a disease. After immunization, the body produces antibodies against the disease.

Aren't most American children immunized?

Almost half the children in a recent study lacked preschool immunizations, even though their parents were relatively affluent and had insurance covering the service. As a result, many cases of preventable measles, whooping cough and other diseases occur.

When should my child be vaccinated?

Recommendations change from time to time, but vaccines usually start by two months of age and are finished by six years of age. The Td vaccine is given again when your child is 14-16 years of age. Some shots are given earlier to children who live in geographical areas where certain diseases are more common.



What is the recommended vaccination schedule?

By 15-18 months of age, all children should complete a schedule of vaccinations that includes four doses of diphtheria and tetanus toxoids and pertussis vaccine (DPT); three doses of oral polio vaccine (OPV); one dose of measles, mumps, rubella vaccine (MMR); and three to four doses of *Haemophilus influenzae* type b conjugate vaccine. In addition, hepatitis B vaccine has been recommended since 1991 for universal immunization of infants.

Completion of this series for 90% of all children by their second birthday is the goal adopted by the Public Health Service for the year 2000.

A vaccination table for children can be found on page 2.
A vaccination table for adults can be found on page 4.

Insert to *Iowa Medicine*, August 1994



A PICTURE OF HEALTH . . .
Both children and adults need vaccinations. Get them now and keep them up to date.

RECOMMENDED SCHEDULE FOR ACTIVE IMMUNIZATION OF NORMAL INFANTS AND CHILDREN

Age	Vaccine
Birth	HBV*
2 months	DTP, TOPV, HbCV, HBV
4 months	DTP, TOPV, HbCV
6 months	DTP, HbCV (third dose may be given at 6-18 months)
15 months	MMR, HbCV
15-18 months	DtaP, TOPV
4-6 years	DTaP, TOPV, MMR
11-12 years	MMR (unless second dose was given previously)
14-16 years	Td

HBV — hepatitus B virus vaccine
DTP — diphtheria and tetanus toxoids and pertussis vaccine
DTaP — diphtheria and tetanus toxoids and acellular pertussis vaccine
MMR — measles, mumps and rubella vaccine
HbCV — Hemophilus influenzae type b conjugate vaccine
TOPV — trivalent oral polio vaccine
Td — tetanus and diphtheria vaccine (reduced dose of diphtheria)

***Restrictions for Immunocompromised Infants and children**

This table was provided by James Bale, Jr, MD, professor in the University of Iowa Division of Pediatric Neurology. It was taken from "Infections in Children: A Source Book for Educators and Child Care Providers".

When should my child not be vaccinated?

If your child has certain types of cancer or disease or is taking a drug that lowers the body's ability to resist infection, some vaccines shouldn't be given. The mumps and measles vaccines shouldn't be given to children who have a serious allergy to eggs; the measles, mumps and rubella vaccines shouldn't be given to pregnant women. If your child has had a serious reaction to earlier shots in the series of a group of shots, your family doctor may want to talk to you about the pros and cons of giving the child the rest of the shots in the series.

What is DTP vaccine?

DTP is actually three vaccines in one and protects against diphtheria, pertussis and tetanus. It is given as a series of five shots. *Diphtheria* is a disease that attacks the throat and heart and can lead to death. *Tetanus,* also called lockjaw, can lead to severe muscle spasms and death. menopause because menstrual cycles are irregular.

DTP shots protect your child from tetanus and diphtheria for about 10 years. After this time, they will need booster shots. *Pertussis*, also known as whooping cough, can lead to pneumonia, convulsions, brain damage and death.

After vaccination, the area where your child received the shot may be swollen or red. The child may have a fever and be fussy and sleepy for a day or two. Rarely, DTP vaccine can cause serious problems such as a seizure (see sidebar).

What is OPV vaccine?

Oral poliovirus vaccine helps prevent polio. It's given four times as drops of the vaccine in the mouth. Polio can cause muscle pain and paralysis of legs or arms. It can also lead to death. Polio is uncommon in the US because of vaccination, but is more common in other parts of the world.

In extremely rare cases, the OPV vaccination can cause polio in the child who is vaccinated.

What is MMR vaccine?

The MMR vaccine protects against measles, mumps and rubella. *Measles* causes fever, rash, cough and a runny nose and lasts one to two weeks. It can also cause ear infections and pneumonia and can lead to more serious problems such as brain swelling. *Mumps* causes fever, headache and painful swelling of one or both of the saliva glands. It can lead to meningitis or cause the testicles of boys or men to swell, making them unable to father children. *Rubella* is also called German measles. It isn't usually serious, except to unborn babies. This is why it's so important to immunize children against rubella. Common side effects of MMR vaccine are rash or fever.

What is HbCV vaccine?

Haemophilus influenzae type b is a leading cause of meningitis, pneumonia and throat infection. This vaccine, also called the Hib vaccine, is given as three or four shots and has no serious side effects.

What about hepatitis B vaccine?

Hepatitis B infects the liver and can cause liver disease, liver cancer and death. No serious side effects have been noted in children receiving hepatitis B vaccination.

Study of DTP risk

A study published recently in the *Journal of the American Medical Association* found no statistically significant increased risk of neurological illness following immunization with DTP vaccine. All major advisory bodies in the US, Canada and United Kingdom conclude that the benefits from DTP vaccine clearly outweigh potential risks from vaccine administered according to current guidelines. Pertussis or "whooping cough" was once a common childhood disease. It produced prolonged violent coughing and led to death in some cases. Prior to DTP vaccine, whooping cough killed five of every 1,000 children born in the US.

Why do adults need immunizations?

Many people believe shots are for children, but adults also need immunizations to protect them against certain diseases. Sometimes immunizations are needed to boose protection that may be wearing off or to make up for immunizations missed in childhood. Some immunizations are needed only after a person reaches adulthood.

What immunizations do adults need?

Requirements depend on age, health status, lifestyle and occupation. Immunizations commonly needed by adults are tetanus-diphtheria, measles, mumps, rubella, influenza, pneumococcal pneumonia and hepatitis B.

What about flu shots?

The flu is a viral illness causing fever, chills and muscular aches. More severe disease can result. Because of the epidemic potential of the flu, it is recommended the following groups be immunized: adults and children with chronic heart and lung disease including asthma; people over age 65; adults and children with other chronic illnesses such as diabetes, kidney disease, etc. Flu shots are given annually.

What if I'm traveling abroad?

Some immunizations may be required or recommended for foreign travel. Cholera and yellow fever vaccination may be required; polio, typhoid, malaria prophylaxis, immune globulin and other vaccines may be recommended depending on the country. Generally, no extra immunizations are needed for travel to Europe.

Where can I get immunizations?

All of these immunizations are available from most physicians and clinics. The tetanus-diphtheria, measles or rubella immunizations are also available at many county public health clinics. Some counties sponsor influenza immunization clinics for senior citizens each fall. Call your local health department or the Iowa Department of Public Health (immunizations division), 515/281-4917 for information.

Recommended immunizations for most adults

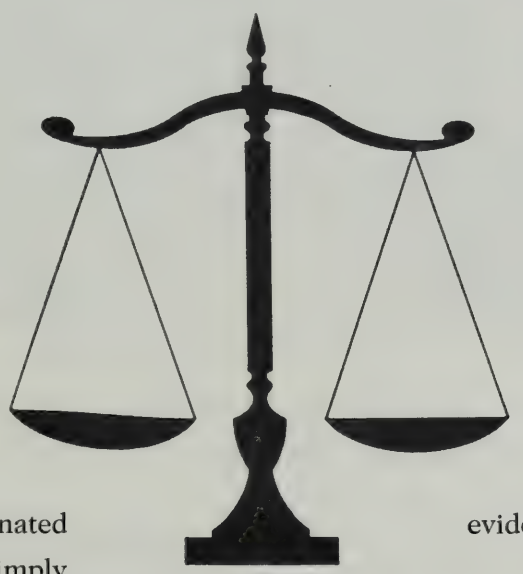
Age group	Definitely recommended	Recommended under some circumstances
18-30	Tetanus-diphtheria Measles Mumps Rubella	Hepatitis B Influenza Pneumococcal
31-64	Tetanus-diphtheria	Mumps Rubella Hepatitis B Influenza Pneumococcal
Over 65	Tetanus-diphtheria Influenza Pneumococcal	Hepatitis B

This information on vaccinations for children and adults has been compiled from publications of the American Academy of Family Physicians, the American Academy of Allergy and Immunology and the Iowa Department of Public Health. As a service to IMS member physicians, this insert may be photocopied for placement in clinic reception areas. Original inserts may be purchased from the IMS for 15 cents each. Call Jane Nieland or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

energies by the institution for the benefit of a relative few is hard to justify when the needs of so many are unattended. According to a recent study, the median charge for each liver transplantation was $145,795. The mean cost of the follow-up care in the first year alone was an additional $20,556 per patient.

Trite but true argument

The common response is concern over the amount of basic care—immunization programs, prenatal and prevention care — which could be provided to so many for the same mount of money. To some this argument is trite, but it happens to be true. The cost of a single liver transplant would help many people in need obtain basic medical care.



In addition, there are specific considerations of the resource in question, donated livers. The supply is not simply limited but is absolutely scarce. Unlike dialysis equipment or ICU beds, it is non-renewable. For patients with end-stage liver disease, there is no other option. Only a few thousand liver transplants are performed each year (1680 transplants in 1988), a small minority of which are for alcoholic cirrhosis. However, the addition of 30,000 potential recipients each year (the number of patients who die of alcoholic liver disease) would render the existing scarce supply inconsequential.

The authors of the liver transplant article in this month's *Iowa Medicine* scientific section indicate they will not adhere strictly to criteria which, according to the very research they cite, maximize the chance of success. They propose that alcoholic patients could qualify for transplantation if "the *preponderance* of their ratings are in the low risk group". (Emphasis is mine.) This approach is worrisomely lax. It invites a loosening of the criteria and a drift toward selecting candidates from the much larger group of alcoholic patients who do not meet as many criteria and for whom transplantation of this scarce resource will not be as successful. Admittedly this would increase the institution's experience with liver transplantation. However, it is not the careful stewardship of a vital resource which the public expects.

Yet the response at the University of Iowa may mirror the perspective evident at other leading centers.

Technology driving the system?

In a 1992 article from the University of Nebraska Medical Center at Omaha, the need to ration livers was considered merely a potential problem in the future, not one to be addressed now. The institution's answer to the dilemma of increasing demand is simply to increase supply by, among other approaches, "fostering the concept of organ donation as a part of citizenship" and as a "communal duty".

Such a call to duty is troubling. It suggests the technology and increased expertise of transplantation are driving the system, themselves

The needs of the individual are commonly juxtaposed against those of the community, state or nation.

Americans are not about to disassemble the technological armamentaria of modern health care, nor should we. But the development, distribution and use of medical technology must be regulated by a more robust sense of the common good.

Charles Doughtery, PhD

creating a growing demand whether justified or not. This is the technologic imperative in contemporary medicine: because we can do it, we should do it. In this time of limited resources, this imperative does not serve the public good.

Consistent with therapeutic approach

The notion of responsibility to the public good applies equally to the alcoholic patient with end-stage liver disease. Responsibility for one's illness should be the primary focus when considering the alcoholic for transplantation. Responsibility connotes ownership of the conscious decision to drink.

This view agrees with the therapeutic approach generally taken with alcoholics and with their families—the patient must accept the diagnosis and assume responsibility for therapy. The family must understand the problem is the patient's.

However, rather than considering the alcoholic responsible for his or her drinking, we too often label the alcoholic patient as blameworthy, a response laden with a sense of moral failure. Yet, as the UIHC authors correctly suggest, this approach assures a rough slide down an ethically tenuous slope. Few of us are free of behaviors which do not present some risk to our health.

However, rejecting this labeling of alcoholics does not justify transplanting scarce livers in alcoholic patients with end-stage liver disease. They do not deserve moral judgment but are responsible for their drinking.

Consequently, those who cannot benefit from their damaged livers — victims of trauma, of certain congenital and acquired conditions — should have priority in transplantation over alcoholic patients who have not accepted responsibility for their originally healthy ones.

Rejection of the alcoholic patient for liver transplantation may seem harsh and uncaring. It is neither. This position reflects a serious consideration of medicine's responsibility and the needs of society.

Must respond to common good

Clearly our profession must continually examine the appropriateness of our values for our patients. The allure, challenge and opportunities of specific technologies notwithstanding, we must respond to the exigencies of the common good. We are not, nor can we be, simply enclaves of specialized pursuits among the cries and expectations for a more just, more balanced system of health care. IM

Responsibility for one's illness should be the primary focus when considering the alcoholic.

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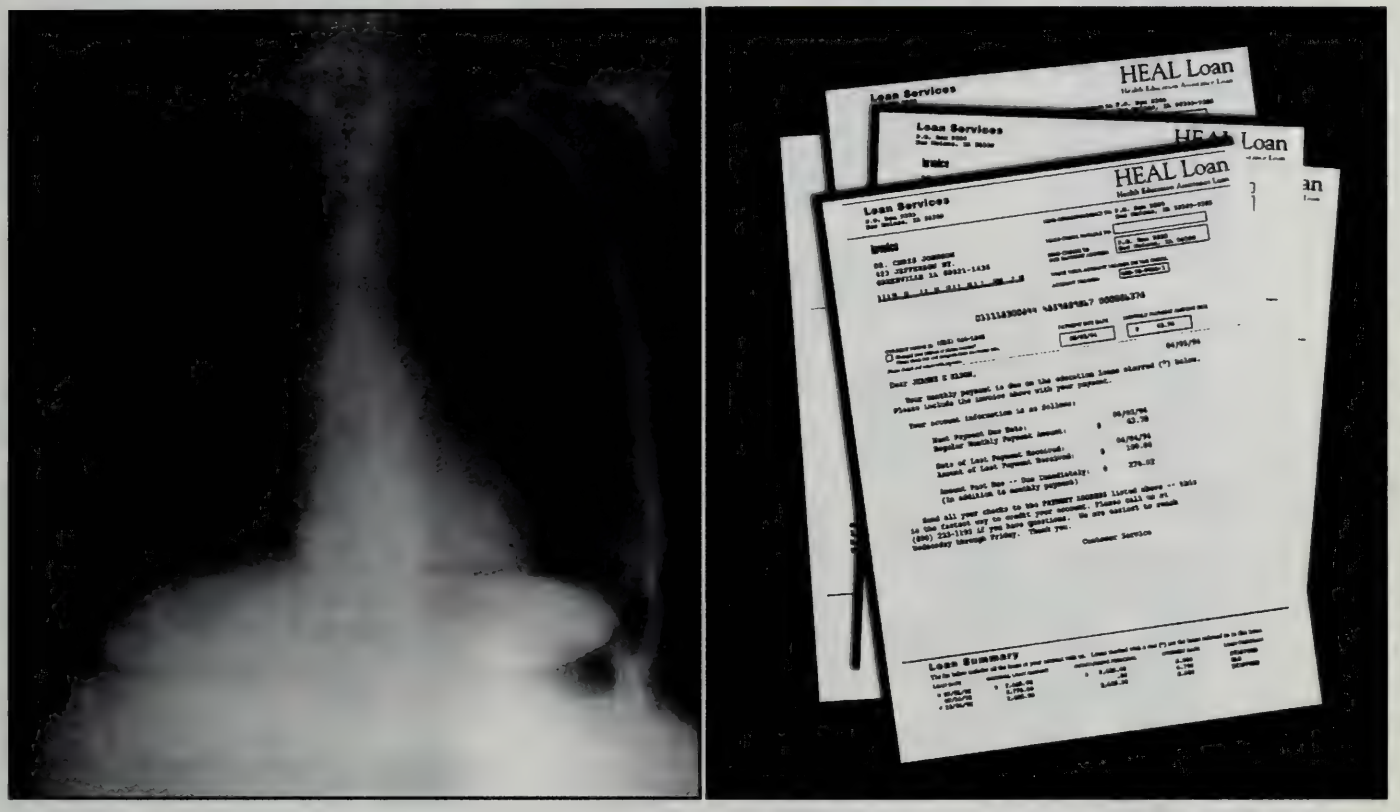
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The Journal
of the Iowa Medical Society

Transplantation of patients with alcoholic liver disease

● *Terri Gerdes, MD; William Yates, MD; Maureen Martin, MD; Douglas LaBrecque, MD*

Alcoholic cirrhosis is the most frequent cause of liver failure in the United States, affecting one to two million Americans. Transplant centers are facing the difficult decision of how to select candidates for hepatic transplantation. Liver transplantation for patients with alcoholic liver disease raises controversial economic and ethical questions. With increasing pressure to control costs and properly allocate scarce resources, physicians will be required to justify to the community, insurance companies and ethics committees, their selection criteria for liver transplantation.

Prognostic dilemma

Earlier studies suggested alcoholics generally had a poor prognosis and unsatisfactory rates of survival after transplantation. More recent data, however, show that alcoholic patients with end-stage liver disease who meet stringent selection criteria may achieve a favorable outcome.[1,2] The dilemma is to determine what these criteria should be for the alcoholic patient.

The duration of abstinence, the sole prognostic criterion at many centers, has not been reliable when used as the sole predictor of risk for recidivism. Several transplant programs have begun to review prognostic indicators of alcoholism and develop their own criteria.

Beresford et al, University of Michigan, was one of the first groups to analyze pretransplant factors which predict favorable post-transplant outcome.[2] In their "rational approach to liver transplantation for the alcoholic patient," three factors suggestive of a long-term remission from alcohol dependence were discussed: 1) the extent to which alcohol dependence is recognized by patients and their families; 2) the degree of present social stability; 3) the nature and extent of changes in lifestyle conducive to long-term abstinence.

Members of the departments of transplantation and psychiatry at California Pacific Medical Center in San Francisco have also looked at similar predictive factors.[3] They concluded that categorization of patients with alcoholic liver disease into predefined risk groups for recidivism and noncompliance accurately predicts pre- and post-transplant behavior. Using this model, risk categories for liver transplantation were developed at the University of Iowa Hospitals and Clinics (UIHC). (See Table 1 next page.)

Iowa transplant criteria

A total of 89 liver transplants have been performed at UIHC since 1984. Fifty-two of these have occurred since 1992. Evaluation of patients under consideration for surgery has generally included extensive screening laboratories, abdominal ultrasound with doppler examination of the portal vasculature, computerized tomography of the abdomen, cardiac, pulmonary and renal function tests and consultations by anesthesia, gynecology and social services. A total of 86 patients have been evaluated for liver transplant since November, 1992. Alcohol abuse was the primary cause of liver failure in 21 of these patients. Several patients have been denied liver transplantation due to medical contraindications and six due to severity of alcoholism or psychosocial reasons.

In an effort to standardize the procedure for evaluating a patient's eligibility for liver transplantation, the UIHC Department of Psychiatry began a liaison service to the

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for August 1994.

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Transplantation of patients with alcoholic liver disease

continued

TABLE 1
IOWA TRANSPLANT CRITERIA

	Risk category	
Criteria	**Low**	**High**
Favorable alcoholism prognosis*	Yes	No
Continued drinking after learning that alcohol had damaged their liver	No	Yes
Signed alcohol compliance agreement	Yes	No
Social support	Good	Poor
Psychiatric contraindication to transplant†	No	Yes

**HRAR Score of three or less (see Table 2) or >12 months documented sobriety*
†Relative psychiatric contraindication to transplant: polysubstance abuse, moderate personality disorder, major mood disorder
Absolute psychiatric contraindication to transplant: severe personality disorder, severe mental retardation, dementia or chronic psychosis
Note: Acceptable candidates are generally ranked low risk in all five categories. Occasional acceptance may be granted for candidates with a predominance of low risk ratings.

transplant team in 1992. Since that time, all patients referred for liver transplant have received a psychiatric evaluation as part of their routine pre-transplant work-up. This evaluation includes a psychiatric history, assessment of psychosocial functioning, current mental status examination and, if applicable, a review of alcoholism history.

Five standard measures are currently in use as part of the initial evaluation of candidates. The first two are the Mini-Mental State Examination (a test of cognitive function) and a Trails-Making Test (a screening tool for encephalopathy).

The third is the Psychosocial Assessment of Candidates for Transplantation (PACT).[4] PACT addresses social support, psychological health, lifestyle factors (including other drug use and medical compliance) and understanding of transplant and follow-up. It is scored on a scale from 1-40; a score of 32 and above is the standard for good psychosocial functioning.

A fourth measure, the Alcoholism Prognosis Scale for Transplantation (APST), quantifies alcoholism prognosis. It addresses additional important predictive factors associated with alcoholism.[5] These include the patient and family's acceptance of alcoholism, substitute activities which replace time spent drinking and an understanding of the consequences of resuming drinking. On a scale of 1-20, a score of 15 or greater is the standard for good psychosocial functioning in the context of alcoholism.

Last, the High Risk Alcoholism Relapse Scale (HRARS) predicts the likelihood of recidivism (returning to drinking).[6] This scale explores years of heavy drinking, usual number of daily drinks and number of prior alco-

TABLE 2
HIGH RISK ALCOHOLISM RELAPSE SCORE

	Point score		
Criteria	**0**	**1**	**2**
Years of heavy drinking	<11	(11-25)	>25
Daily usual drink number	<9	(9 to 17)	>17
Number of prior alcoholism inpatient treatment episodes	0	1	>1

Low risk — Sum of three factors = 0, 1, 2, 3
High risk — Sum of three factors = 4, 5, or 6

holism inpatient treatment episodes. We use a score of 3 or less on a scale of 1-6 as indicative of low risk of relapse (Table 2).

Recidivism and noncompliance

In early 1993, UIHC established criteria for acceptance as a transplant candidate. All psychiatric and alcoholism data on a candidate is compiled and the patient is assigned a high or low risk category for liver transplantation. All patients are asked to sign a patient compliance contract developed by the authors. Following is a summary of the criteria currently in use at UIHC.

LOW RISK GROUP (Acceptable for transplantation)

1. Favorable alcoholism prognosis (HRARS score 3 or less, or > 12 months sobriety).
2. Never been told that alcohol was damaging liver or stopped drinking when told alcohol was affecting liver.
3. Signed the patient compliance agreement.
4. Good social support system (scores >32 on PACT or >15 APST).
5. No absolute psychiatric contraindications.

HIGH RISK GROUP (Not acceptable for transplantation)

1. Unfavorable alcoholism prognosis (HRARS >3).
2. Inability to maintain abstinence despite being told alcohol was damaging liver.
3. Refusal to sign patient compliance agreement.
4. Poor social support system (<32 on PACT and <15 APST).
5. Psychiatric contraindications to liver transplantation.

Who qualifies?

In order to qualify for acceptance for liver transplantation, candidates should have a preponderance of ratings in the low risk group. Patients who do not qualify due to psychiatric or alcoholism criteria are clearly informed of the acceptance criteria. These patients may be given an opportunity to be reassessed by sustaining abstinence, signing the contract or enrolling in rehabilitation. Some patients would be eligible to receive a liver transplant based on these criteria, but may have medical contraindications which result in exclusion as a candidate.

Several authors have addressed the question of whether alcoholics should be allowed to compete equally with other patients for donated organs. Moss and Siegler, in a special communication to the *Journal of the American Medical Association* in 1991, proposed patients who develop end-stage liver disease through no "fault" of their own should have priority for receiving a liver transplant over alcoholics.[7] Their primary argument is a moral one, based on considerations of fairness to all patients needing liver transplants. In light of the scarcity of donor livers, the authors state it is fair to hold people responsible for their choice. Such arguments advocate allocation of organs preferentially, for example, to a child dying of biliary atresia rather than to a patient who developed liver failure due to lifestyles choices.

Cohen et al argue that there is no good moral or medical reason to categorically exclude alcoholics as liver transplant candidates.[8] They maintain that if we disqualify alcoholics because their condition resulted from their own conduct, we should also refuse to treat accident victims injured because of failure to wear seatbelts, diabetic patients with complications because of poor compliance with diet or smokers who develop lung disease or who become coronary artery bypass candidates. Most data suggest lifestyle accounts for 70% of all medical and psychiatric illnesses in America, which would tend to invalidate the moral argument. There is also growing data that, for many, alcoholism is a disease with a strong genetic predisposition rather than a lifestyle choice.

The medical argument that post-transplant survival rates are significantly lower for patients with alcoholic cirrhosis than other recipients of liver transplants has been dispensed. The consensus at most sites is that, with careful selection, survival rates of alcoholic patients are comparable to their nonalcoholic counterparts and few are returning to drinking. The data does not justify transplantation of all alcoholics, but do support the contention that accurate identification of prognostic factors allows transplant centers to select appropriate candidates for whom liver transplantation is justified.

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AMA trustee comments on Iowa visit

In June, I visited Des Moines and did interviews about the American Medical Association's Patient Protection Act (PPA) with key area journalists.

I was sent to Iowa because the Senate Finance Committee, of which your Senator Grassley is a member, was about to vote on the PPA as well as other significant health care measures. The AMA wanted to let Iowans know what was on the table and what was at stake for them. As many of you know, the PPA would ensure that managed care plans put patient care before the bottom line. It also would ensure that physicians would be able to contract with managed care plans and that they would not be deselected without good reason.

I was interviewed by WHO-AM, the *Des Moines Business Record* and, along with IMS president-elect, Dr. Joseph Hall, the *Des Moines Register*. All of these interviews went extremely well. WHO-AM aired brief feature stories on the PPA during its newscasts later that day.

In addition, the June 20 issue of the *Des Moines Business Record* ran a story on the PPA, which many of you may have read. While the story was extremely positive, the reporter made several mistakes. In a quote attributed to me, she wrote, "[health care professionals] put dollars first and patients second." I actually said that "many [for-profit managed care plans] put dollars first and patients second." She also incorrectly referred to the PPA as the "Patient Rights Act."

I would like to thank the staff of the Iowa Medical Society for helping me arrange such an exceptional visit. It was apparent to me by how well I was treated by each of the reporters that the staff of the Iowa Medical Society has done an excellent job working with the media. I also would like to thank Dr. Joseph Hall for his willingness to jump into the fire with little advanced notice.

I am sure that as the reform process continues, we will join together in pursuit of a health system reform plan that benefits all Americans.—*Donald Lewers, MD*

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Extramedullary plasmacytoma of skin, bowel and bladder

● *Dean Gesme, Jr., MD; Dennis Boatman, MD; Gary Weinman, MD; Hamed Tewfik, MD*

Extramedullary plasmacytomas are composed of malignant plasma cell aggregates within non-hematopoietic tissues. Extramedullary plasmacytomas may arise *de novo* as solitary soft tissue tumors or may grow as multiple metastatic sites in patients with underlying multiple myeloma.

This case report displays the varied range that extramedullary plasmacytomas can manifest in association with multiple myeloma.

Case history

A 49-year-old white female with a seven-year history of advanced refractory multiple myeloma was admitted to the hospital because of gross hematuria. Prothrombin and partial thromboplastin times were normal; however, the platelet count was markedly depressed as a result of extensive previous treatment and marrow replacement by malignant plasma cells. Cystoscopy was performed as hematuria persisted despite platelet transfusions. A mass noted within the bladder was resected transurethrally. Local irradiation to 3,500 cGy was administered with no further hematuria.

Six months thereafter, the patient was hospitalized with hypotension and massive upper gastrointestinal bleeding. Packed red cells and platelets were transfused along with intravenous fluid rehydration. Upper gastrointestinal endoscopy revealed an ulcerated tumor in the area of the ampulla of Vater just distal to the duodenal bulb. Biopsy revealed a malignant plasmacytoma within the wall of the small bowel (Figure 1). Irradiation to 2,000 cGy resulted in resolution of the gastrointestinal bleeding.

The patient also developed two 1 cm lesions within the skin overlying a subcutaneously implanted Infuse-a-port venous access device which had been implanted in the right infraclavicular fossa several years earlier. These nodules were presumed to be extramedullary plasmacytomas. They quickly disappeared following 1,500 cGy of radiation therapy to the local area.

Discussion

Multiple myeloma, the most common plasma cell malignancy, is characterized by diffuse bone marrow infiltration with neoplastic plasma cells. Multiple myeloma is usually associated with anemia, osteoporosis and multiple plasmacytomas within bone presenting radiographically as osteolytic lesions. Plasma cell leukemia represents a rare sub-

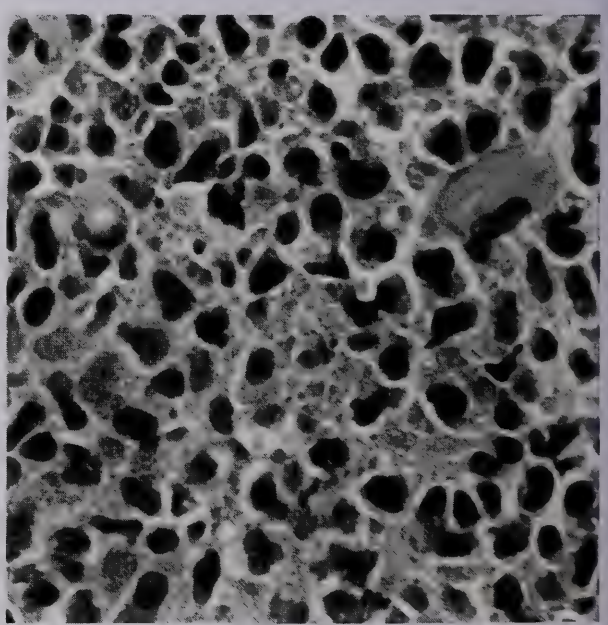


Figure 1. Plasmacytoma biopsied from the small bowel.

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type of multiple myeloma with a very poor prognosis.

Solitary plasmacytomas of bone represent a rare plasma cell dyscrasia in which a single osteolytic site is present in association with a normal bone marrow aspirate and absence of Bence-Jones proteins. Furthermore, any monoclonal protein in the serum and/or urine completely disappears following irradiation of the solitary lesion.

Solitary extremedullary plasmacytomas are differentiated from solitary plasmacytoma of bone solely by virtue of arising in a soft tissue site. Complete response to focal low dose radiation therapy is characteristic. Systemic recurrence following irradiation is diagnostic of underlying multiple myeloma. Such recurrence is seen in 20-30% of patients with solitary extramedullary plasmacytomas and up to 70% of patients initially diagnosed with solitary plasmacytoma of bone.

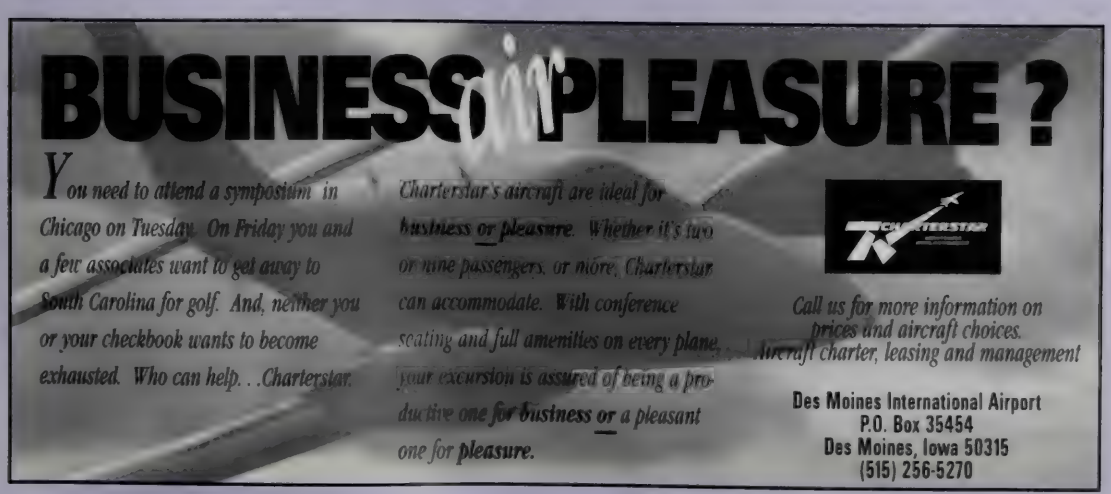
The spectrum of plasma cell dyscrasias is completed with the clinical syndrome of monoclonal gammopathy of uncertain significance (MGUS). MGUS is not associated with bone or soft tissue plasmacytomas and may represent a pre-malignant condition in certain patients. After five to 10 years, up to 20% of patients will have manifested an overt diagnosis of multiple myeloma.

Improved diagnostic techniques including sophisticated immunohistochemical studies and gene rearrangement assessments have improved the diagnostic accuracy in plasma cell dyscrasias. Advances in endoscopic techniques have improved our appreciation of the broad variety of sites in which plasma cell tumors may arise.

This case highlights the development of extramedullary plasmacytomas as an end stage manifestation of multiple myeloma. Large studies to assess the incidence and sites of extramedullary plasmacytomas have rarely been published. Case reports, however, have documented the occurrence of solitary or multiple extramedullary plasmacytomas in nearly all soft tissue sites in the body. These include uvea, conjunctiva, parotid, nasopharynx, larynx, lung, mediastinum, esophagus, stomach, small bowel, colon, pancreas, kidneys, bladder and urethra. Additional case studies document occurrences in the thyroid, breast, brain, lymph nodes, skin and skeletal muscle.

A recent report also details a subcutaneous extramedullary plasmacytoma at the site of a prior bone marrow biopsy suggesting mechanical tumor implantation at the surgical site. The nodules present over the Infuse-a-port venous access device found in the patient described in this report suggest a similar source of tumor seeding.

Editor's Note: A bibliography for the article is available from the authors or the editors of Iowa Medicine. IM



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Dad's garden

Flowers are the sweetest things God ever made and forgot to put a soul into.

Flowers have an expression of countenance as much as men or animals. Some seem to smile; some have sad expressions; some are pensive and diffident; others are plain, honest and upright, like the broad-faced sunflower and the hollyhock.

Henry Ward Beecher

As a youngster I hated toiling in our family garden. It was Dad's garden, for all Mother got out of it was hours of canning vegetables and preparing meals from the produce. That garden, comprising an area of two city lots, was Dad's delight. It also entailed a lot of work. It was strictly an organic masterpiece because Dad was a perfectionist. Every row was straight and precisely measured one to another. An elaborate irrigation system provided water to row after row of potatoes, green beans, tomatoes, squash and cucumbers, not to mention the radishes, carrots and peas.

No insecticides were used. I hated the task of manually removing those stinking potato bugs from the seemingly endless rows of potatoes. The hot Nebraska sun and wind of the mid '30s seemed akin to a furnace and the tasks involved in that garden seemed endless. Never, I vowed, would I ever engage in such slavery once I grew older.

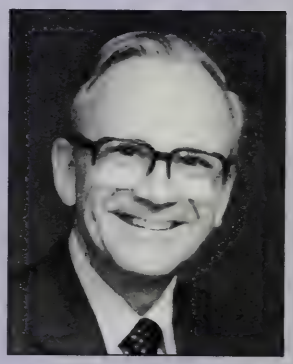
Guess what? Something happened. I came to realize in later years that my dad instilled in my life a desire to be involved with growing plants. Perhaps it even stimulated me to watch and nurture the growth of children, hence to become a pediatrician.

Now there is a little rustic sign, a gift from a grandchild, in my flower garden: "Dad's garden". I enjoy the many flowers around our house and also serve as the volunteer gardener for the flower gardens around the 1876 Victorian mansion at the Living History Farms. The flowers and the herbs are my delight; the physical fatigue is a small price to pay for enjoying the beauty of the flowers. The enjoyment is not mine alone, for the sharing of the gardens with friends and visitors provides a joy of giving something back. The early morning hours are the best, just me and the birds and the flowers. Being alone (yet not really being alone for a greater Being is always near in the gardens) provides a peace of solitude truly described by Dorothy Gurney:

The kiss of the sun for pardon,
The song of the birds for mirth;
One is nearer God's heart in a garden
Than anywhere else on earth.

The love of life and nature's wonders is good medicine.

I trust my readers accept this digression from the world of medicine. However, this is not a true digression for the love of life and nature's wonders is good medicine. I would not hesitate for a moment to prescribe gardening to anyone. It's good for what ails you. IM



Marion Alberts, MD

11TH ANNUAL

PROGRESS IN INTERNAL MEDICINE

October 6-7, 1994

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Iowa City, Iowa

TOPICS

Cardiology
- Advances in the treatment of acute myocardial infarction
- Current treatment of congestive heart failure
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Chronic Cough: A Multidisciplinary View
- Sinusitis
- GI reflux
- The lung

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- Rational selection and evaluation of diagnostic tests

Challenges in Medical Practice
- Hpochondiasis
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- Peptic ulcer disease: NSAIDS to microbes
- The obstructed biliary system

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- How to read critically: statistics for idiots

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- Evolving concepts in the diagnosis and management of MS

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- The breathless athlete

WORKSHOPS

- Medical informatics: making your computer useful
- The female genital (pelvic) exam
- The male genital/rectal exam
- Mechanical ventilation: basics and new issues
- Changes in diabetes management: interactive cases
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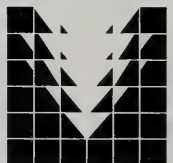
SPECIAL EVENTS

Big 10 Football, Saturday, October 8: Iowa vs. Indiana. Limited number of tickets available to course participants; first come, first served.

REGISTRATION

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CME and new technology

The Iowa Legislature has expanded access to the Iowa Communications Network, the state's much-heralded fiber optic system. Reaching 99 counties, the network may be linked with community hospitals and related health care facilities. While there were no funds appropriated, facilities may use their own resources to establish the connection.

The primary intent is to encourage electronic sharing of patient-related information among health care providers. This capacity may be most useful to physicians in small facilities lacking full-time coverage by pathologists, radiologists and other specialists. The physician will be able to transmit clinical information to physicians at a referral hospital to obtain almost instantaneous consultation.

The linkage may facilitate other types of assistance. Using Internet, an international computer-based network that is a true interstate of the information highway, physicians have been able to gain access to innumerable bibliographic files and bulletin boards related to medicine and health care. Most of these resources are in the public domain and therefore can be used without special fees. While Internet is already available to users via telephone modem, the fiber optic link with the state's universities should greatly expand utilization of related databases.

What of other educational programming using the network? The interactive video capacity of the network will enable two or more sites to plan joint clinical conferences, either to review specific cases or discuss advances in the medical care of selected conditions and disorders. The technology to support this format has been available before, but has been infrequently employed.

Herein lies a challenge to all persons and programs who anxiously await the installation of the fiber optic network to expand CME programming within their communities. The recent adage "build it and they will come" may not apply. There is a basic level of discomfort among many physicians about sitting before a color monitor with colleagues and then "having a conversation" with someone at a remote site while speaking in front of a video camera. Most physicians older than 30 years of age (that is most physicians) did not have the experience of having their childhoods recorded for posterity using these devices; they are among a generation of adults whose children or grandchildren program the home VCR.

The recent adage "build it and they will come" may not apply.

The task for CME program planners will be to develop interactive sessions that are of high interest. Here the worlds of clinical consultation and didactic CME may find harmony. For example, a thyroid disease expert at one site may offer a short talk followed by consultation relating to specific cases of thyroid patients collected by physicians at other sites.

The utility of this kind of program may help old dogs learn new tricks. IM



Richard Nelson, MD

Classified Advertising

Emergency Medicine Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Program Director, Family Practice Midwest—Fifteen residents in this highly acclaimed residency oriented in its teaching to rural medicine. Only program in the state to match all slots. Strong faculty credentials and superb relationship with private attending physicians who participate in the teaching program. Excellent balance of clinical patients with didactic teaching. Full authority and autonomy is vested in the program director to allow effective leadership. Excellent salary and benefits. Wanda Parker, E.G. Todd Physician Search, One Byram Brook Place, Armonk, New York 10504; 800/221-4762, fax 914/273-5895.

General Surgeon BE/BC—The Department of Surgery at the Mayo Clinic in conjunction with the Decorah Clinic is seeking a broad-based general surgeon to join the Mayo Regional Facility in Decorah, Iowa, 70 miles south of Rochester, Minnesota. This position offers an excellent opportunity to establish a surgical practice in an established 9-person, Mayo-affiliated medical clinic in this town of about 8,100 with a 60-bed hospital and a county population of 26,000. This opportunity allows practice autonomy, a wide spectrum of general surgery, including some gynecological and orthopedic expertise and excellent salary and benefits. Inquiries to Michael G. Sarr, MD, Department of Surgery, Mayo Clinic, Rochester, Minnesota 55905. Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Anesthesiologist, Des Moines—Mercy Franklin Center is seeking a board certified anesthesiologist to provide anesthesia for electroconvulsive therapy patients. Requires a commitment to provide services on every Monday, Wednesday and Friday morning. Financial arrangements are negotiable. For more information write Paul Jorgensen, Administrator, Mercy Franklin Center, 1818 48th Street, Des Moines, Iowa 50310, 515/271-6160.

Opportunities Available—Family practice, general surgeon, emergency medicine, internal medicine, locums, ob/gyn, occupational medicine, pediatrics, urgent care opportunities available in Minneapolis/St. Paul and leading communities within a 150-mile radius of the Twin Cities. Contact HealthSpan, Physician Services, 2810 57th Avenue North, Minneapolis, Minnesota 55430; 1-800/248-4921 or 612/574-7627.

Emergency Medicine Locum Tenens

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

Marshalltown, Iowa

Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses for full-time. Numerous other Iowa locales. **ACUTE CARE, INC.**, P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

Family Practice, Creston, Iowa—Opportunity for family practice physicians to join existing multispecialty clinic. Community is progressive with excellent schools, quality hospital and abundance of recreational facilities and activities. The position offers professional, financial and lifestyle opportunities not found in metropolitan areas. For more information, contact Mike Brentnall, Creston Medical Clinic, P.C., 515/782-2131 or mail CV to 526 New York Avenue, Creston, Iowa 50801.

General Surgeon—Wanted to join primary care group of 8 established physicians with a captive on-site referral base. This position offers outstanding professional, financial and lifestyle opportunities with outstanding school system. Please call Linda Cohrt, Family Medical Center (515/673-6762) or mail CV to 1225 C Avenue East, Oskaloosa, Iowa 52577; fax 515/672-2258.

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Emergency Medicine Spencer, Iowa

Immediate opportunity for primary care trained or experienced emergency physician. Spencer Municipal Hospital is a progressive 131-bed hospital with a staff of 30 physicians representing major specialties. 8400 volume/24-hour shifts. Spencer is a community where country charm and modern lifestyles go hand in hand. Vacation year round on the Iowa Great Lakes of Lake Okoboji and Spirit Lake. Spencer also has a variety of restaurants and shops, much more than typically found in a community of 12,000. Highly rated award winning schools make Spencer an excellent place to raise a family. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Fairfield, Iowa—Over $100,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

Venture North—To the northwest suburbs of the Twin Cities, Minnesota. Full and part-time positions are available for BC/BE physicians in FP, IM and OB/GYN and for physician assistants and nurse practitioners. Get back on course with the owned and affiliated clinics of North Memorial Medical Center. Choose large, small, urban or semi-rural practices. Plus, receive up to $15,000 (extenders up to $10,000) on start date through our community service program. If interested, send CV or call in confidence to North Medical Programs, North Memorial Medical Center, 3300 Oakdale Avenue North, Robbinsdale, Minnesota 55422-2900; 800/275-4790.

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Family Practice, Carroll, Iowa—Outstanding professional opportunities for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are available for either experienced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more information, call Randy Simmons, Vice President, at 1-800/382-4197, or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

BC/BE Internist—For 84-physician multispecialty group on the scenic bluffs overlooking the Mississippi River where Iowa, Illinois and Wisconsin meet. Excellent call schedule in this 17-member department of physician-owned clinic with its own HMO. Professional administration enables physicians to concentrate on the practice of medicine. Outstanding lifestyle, excellent income guarantee, complete benefits and ownership eligibility. Call or send CV to Denis Albright, Medical Associates Clinic, 1000 Langworthy, Dubuque, Iowa 52001; 800/648-6868.

Iowa City—Towncrest Internal Medicine, a group of 14 physicians now entering its 41st year of private practice, seeks 1 or 2 young general internists to replace retiring senior partners. Cultural and athletic events comparable to larger city but the safety and convenience of the smaller town. An excellent environment in which to practice and in which to raise and educate a family. Please send CV to Administrator, Towncrest Internal Medicine, 2460 Towncrest Drive, Iowa City, Iowa 52240.

Emergency Medicine Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Minnesota—BC/BE family practitioner to expand current 23-member department. Enjoy a lifestyle of call every 21-23 days and an average 4-day work week. Just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of group earn a highly competitive income and excellent benefits including paid vacation and CME, pension plan, all insurances paid. Please respond with CV to John Bordwell, MD, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-7035.

(Continued next page)

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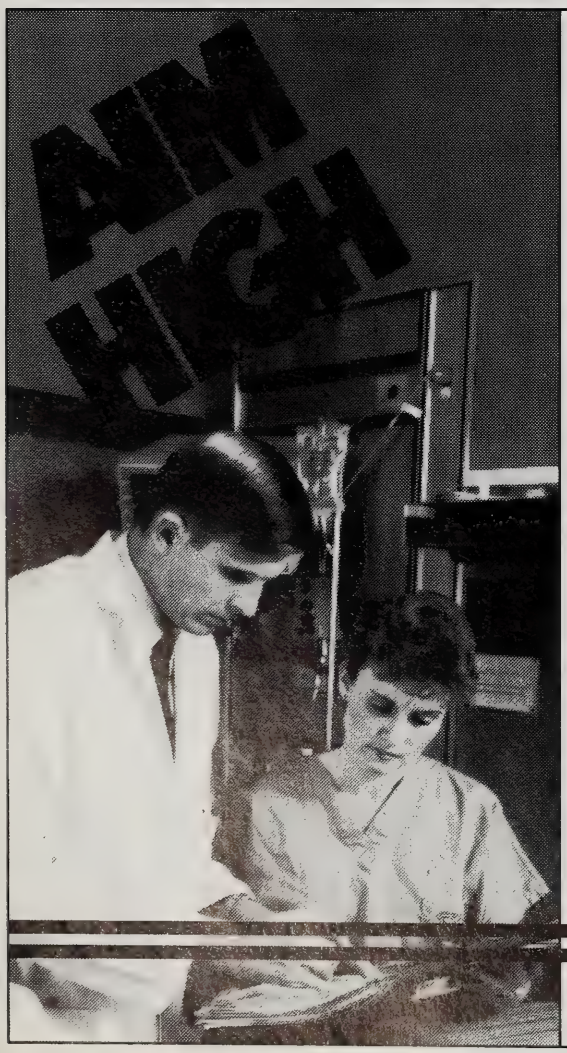
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Clarkson Family Medicine—Opened its doors to an excellent, totally remodeled facility on July 1, 1991. We are now preparing for our first graduation ceremony. Since our first class of residents, we have filled in the Match Program every year with high quality residents. Our patient numbers have exceeded our most optimistic projections, allowing us to consider expanding our resident numbers. An additional physician faculty and associate director are needed to assist us in expanding our program and services while continuing our commitment to the training of physicians for excellence in rural practice, including extensive OB experiences. Responsibilities include direct patient care, resident and student supervision and scholarly activities. Candidates must be board certified in family practice with a desire to participate in the growth of an exciting new program. Strong OB experience is highly desirable. Salary and benefits are extremely competitive and dependent upon experience. Clarkson Hospital takes pride in being a smoke-free environment and does not hire applicants that use tobacco products. EOE. Serious applicants should send letter of inquiry and/or CV to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, Nebraska 68131.

LeMars, Iowa

Seeking quality physicians to practice at a 4300 average volume ER. Director and staff positions. Full and regular part-time. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Health Care Administrator—Accepting applications for the position of Health Care Administrator. Bachelor's degree; Master's prepared (preferred). Medical education institution seeking candidate who has knowledge and experience in practice management and health service administration. Will have strong commitment to community involvement and business development. Interpersonal skills a must. Applicants should submit current resume and a letter of application which should include salary expectations and requirements to: Director, Family Practice Residency Program, 516 West 35th Street, Davenport, Iowa 52806.



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Here's to your Health

The Iowa Medical Society has published 4 patient inserts in recent months. In addition to the insert in the center of this magazine on vaccinations, 3 other patient inserts are also available: low back pain, menopause and estrogen therapy and prostate cancer. Original inserts may be purchased for 15 cents each plus postage. A bill will accompany your insert order.

Call Jane Nieland or Bev Corron at 800/747-3070 or 223-1401 to order inserts or send the completed form below to: *Iowa Medicine,* 1001 Grand Avenue, West Des Moines, IA 50265.

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Address _____

City _____ State ____ Zip _____

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Practice is located in picturesque Monmouth, Illinois, a city of 10,000 with a draw of 25,000—only 30 minutes from the Quad Cities and 3 hours from St. Louis and Chicago. For consideration contact:

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319/338-3623

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Michael L. Long, MD
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General Ophthalmology

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Todd W. Gothard, MD
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515/223-8685

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Fort Dodge 50501
515/576-7777

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Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
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319/362-8032

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Eugene Peterson, MD
Richard B. Merrick, MD
3901 Ingersoll
Des Moines 50312
515/274-9135

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James W. White, MD
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Des Moines 50309
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West Des Moines 50266
515/225-7761
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Marshalltown 50158
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Des Moines 50314
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Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

(Continued next page)

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James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
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Cedar Rapids 52401
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Strategies for the future

Feeling harried and harassed by recent and proposed changes in the health care delivery system? It might help you to know that the Iowa Medical Society is initiating a new educational effort called "Futures—Strategies for Tomorrow's Practice". The IMS Futures program will begin with a series of five regional meetings at which we will gather feedback about what is happening locally. In that vein, I thought it might be interesting to give you a brief account of what is happening in my area.

Presently in Dubuque and the tri-states, a multispecialty group offers its own HMO product to employers and Medicare recipients wanting to pay a fixed dollar for their annual health care cost. It received government grant money to help defray start-up cost and has traveled a bumpy road. The product was marketed outside the normal referral area and, without proper controls, suffered a financial setback. Through reorganization, the product is once again viable.

As a result of competitive forces, multiple small specialty groups united to form an Independent Physicians Association (IPA). A Blue Shield HMO—Total Health Network—was marketed for IPA patients. The product was alien to the Dubuque and tri-state medical community and, with very limited data from which to identify problems, the product failed and the Blues withdrew. The Heritage National Healthplan HMO entered the tri-states market in 1988. This product was better adapted to tri-state physician practices and has been more responsive to physician needs. The IPA hired an executive to provide direction for managed care contracting as well as other initiatives.

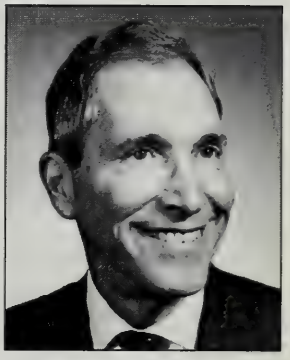
Our hospitals are trying to develop a partnership to minimize overhead. The partnership has been challenged by the Department of Justice. Significant financial resources have been expended for consulting and legal services. Should this challenge be tested in the courts, additional community funds will be channeled to this effort rather than toward upgrading health care services.

Two PHO's (Physician Hospital Organizations) have been created to enable further integration. These entities could provide single-risk contracting adding greater efficiencies for both providers and patients. Since there is divided opinion in our community, a more pessimistic view would hold that employers and third party payors have the power to cause disunity among hospital and physician groups.

We must also recognize that "quality" may mean different things to different players.

We must also recognize that "quality" may mean different things to different players. To the politician, it could be anything that gets he/she re-elected. To employers and third party payors, it's profit. To physicians, it means providing patients with the finest "state-of-the-art" care available.

Developments such as I have just described are happening across the state. The Society's new educational effort is one way we can start taking control of our future. IM



James White, MD

Housing tax credits too good to be true?

Financial services industry often overlooks housing tax credits as one of the best techniques for reducing your federal tax liability.

One of the most effective and frequently overlooked methods of reducing federal tax liability is the Low Income Housing Tax Credit. The federal government recognizes that a tremendous gap exists between the supply and demand for affordable housing in the United States. Fortunately in response to this need, Congress has elected to present investors with a tremendous opportunity. As an incentive to develop low income housing, they authorized the use of a federal tax credit in 1986. Tax credits, unlike deductions, are subtracted dollar for dollar straight off your total tax owed. A dollar of tax credit will save two to three times as much taxes as a dollar contributed to a tax deductible IRA.

150 Percent Credit

Investors in low income housing are projected to receive tax credits equal to approximately 150% of their investment, although sometimes it can range as high as 190% of their investment. The total amount of credits is distributed equally over 10 years. For example, a $10,000 investment would yield tax savings of approximately $1500 per year for the next 10 years, for a total of $15,000. As previously stated, the total may be as high as $19,000 for every $10,000 invested. Depending on factors such as an investor's income and Alternative Minimum Tax (AMT), a taxpayer may be able to reduce their tax liability by as much as $9,900 per year using Low Income Housing Tax Credits.

In addition to the credit, there are other potential benefits which can be realized. Cash flow from operations can result if the properties are profitable. This comes in the form of distribution checks sent directly to investors. Generally, all cash flow distributions are completely sheltered from taxes.

As an equity investor, you also own part of an apartment complex, in addition to the credits and cash flow. When the properties are sold, they may be sold at a profit. Again, a portion of this profit would be distributed to investors and much of this could be sheltered from taxes.

Social Benefits

Aside from the obvious financial benefits generated for the investor, there is also a social benefit. The funds raised are used to develop multi-family housing for modest wage earners and the fixed income elderly. These programs are *not* government projects, tenants must meet certain income criteria, *but their rents are not subsidized.* As in any other apartment complex, the tenants are subjected to references and employment checks to make sure they are desirable renters.

Perhaps the greatest obstacle tax credits face is that they sound too good to be true. That is, until you mention that the only form they are available in is that of a limited partnership. Any time real estate and limited partnerships are mentioned in the same breath, people are conditioned to run for their financial lives! However, these programs differ significantly from the real estate programs commonly known as "tax shelters" that were promoted in the early 1980s.

Figuratively speaking, old tax shelters granted the general partner a license to steal. The fees in the programs were exorbitant and the amount of borrowed money involved excessive. If that wasn't enough, Congress put a stake through their heart in 1986 by eliminating or postponing the tax benefits these programs were designed to deliver.

Partnerships are under much more scrutiny from investors now. Tax benefits are rarely the sole motivating force behind these investments. It should be pointed out however, that should an investor in Low Income Housing Tax Credits receive only the credit and no other benefit, they have done well. The tax credits, if fully earned, are projected to produce a respectable 6 to 14% after tax return on their money.

The other benefits such as cash flow and appreciation and use of the passive losses could enhance the return even more.

As is true of all real estate investments, housing tax credits are not without risk. Tax credits are complicated and not everyone can use them. However, in taking a survey of current and past performance of these properties indicates the results have been very favorable. Demand for affordable housing is enormous and in most markets these properties operate with occupancies in the 95-100% range. This is significantly higher than the breakeven occupancies typically around 65-75%.



Financial planner Don DeWaay says housing credits can be a gold mine for investors.

Do Your Homework

It is important to evaluate each program on its own merits. Always scrutinize the track record of the General Partner. There are always spread sheets or "pro formas" that outline the expected benefits from these investments. Compare these against actual performance on prior programs. Read the prospectus carefully, noting fees and structure of the program. It is to the investor's benefit to keep the fees below 20%. This may sound high, but when you examine what it costs to register and develop a program it is quite reasonable. Also look for programs that use lower leverage or in other terms, lower amounts of borrowed money. Commonly, projects in LIHTC use moderate to low leverage in the 50-80% range. The lower the leverage, the more likely the property is to cash flow.

Prior to investing, you should always know all the particulars about a project. Pay close attention to the real estate markets where the properties are located. Look for a solid employment base and economic growth potential. Also look for areas with high median income which allows the properties to increase rents. A good rental market will enhance the outlook for cash flow and appreciation in the properties value. In short, do your homework. Most of these programs appear to be working well, but they are not uniform at sale. Some definitely offer more potential than others.

If all this sounds too confusing or complicated, the alternative is much easier. Simply continue to write your checks to Washington every April 15th. For that, you get no liquidity, no return and your holding period is forever. When tax credit programs perform as designed, you redirect dollars that would have been used to pay taxes and put them back in your pocket to add to your net worth. With that in mind, it's easy to see why these programs are so widely used by corporations and individuals.

Don DeWaay
DeWaay, Weissenburger and Associates
1102 Grand Avenue
West Des Moines, IA 50265
800/727-4635

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IMS Update

Have you heard about the Iowa Medical Society's new *Futures* program? If you'd like help exploring your options in the new environment, turn to pages 379 and 389 for more information.

Women in Medicine Month

September, 1994 has been designated by the AMA as Women in Medicine Month. According to the AMA, women physicians now number over 125,000, nearly 20% of U.S. physician population.

Women's health conference

Aging, menopause and hormone replacement, domestic abuse and midwifery will be topics at the "Women's Voices — Focus on Health" conference November 18 and 19 at the University Park Holiday Inn, West Des Moines. Special guest will be U.S. Rep. Patricia Schroeder. The conference is presented by the Office of the Lt. Governor of Iowa, the Iowa Department of Public Health and the Iowa Commission on the Status of Women. For more information call Ritaann Carpenter, 515/281-5787.

JAMA predicts specialist surplus

By the year 2000, America will need 225,000 specialists physicians but will have 376,000, according to a study published in a recent issue of *JAMA*.

The study was conducted by the Johns Hopkins School of Public Health and concluded that 40% of all medical specialists in the U.S. could be unnecessary by the end of the decade, regardless of whether health system reform is enacted.

The study was commissioned by the federal Bureau of Health Professions and is based on the assumption that 40-65% of Americans will get their care from HMOs or other managed care entities by the end of the century.

Dr. William Jacott, AMA trustee, said the study shows "medical schools need to allow primary care to have a positive presence so students realize primary care is important."

AMA president-elect in Des Moines

Dr. Robert McAfee, president of the AMA, was a guest speaker at the Midwestern Legislative Conference held in Des Moines in mid-August. Dr. McAfee highlighted the activities of the AMA in the area of violence prevention. Following the conference, he attended a dinner meeting involving IMS trustees and AMA delegates and alternate delegates.

IMS dues statements

The first IMS dues statements will go out in early October. Iowa is unified at the state and county levels. Prompt payment of your dues will be greatly appreciated. IM

Specialty Society Update

The American Medical Directors Association, Iowa Chapter, will hold its annual meeting in Iowa City September 9 in conjunction with the Midwestern Conference on Health Care in the Elderly.

The American College of Cardiology, Iowa Chapter, annual meeting is September 24 at the IMS.

The IMGMA fall meeting will be October 13 and 14 at University Park Holiday Inn, West Des Moines.

The Iowa Psychiatric Society fall meeting will be in Iowa City October 13-15.

The Iowa Oncology Society will hold its annual meeting October 28 in Cedar Rapids.

The Iowa Association of County Medical Examiners will hold a board meeting September 30 to finalize plans for the education and business meeting October 28 in Ames.

AT A GLANCE

Thanks to the nearly 1,100 physicians who returned Iowa Medicine *readership surveys last month. The IMS Board of Trustees is using the results in 1994-95 IMS strategic planning. Survey results and Board recommendations will be reported next month.*

Without explicitly telling doctors or patients, major drug companies are enlisting pharmacists to promote their drugs rather than those of their competitors, reports the New York Times. *Companies will sometimes pay pharmacists cash commissions for arranging a switch in a prescription.*

As of June 30, 1994, there were 664 reported cases of AIDS in Iowa. Eight of those cases were in children under age 12. There have been 39 new cases reported here this year.

Health System Reform

AT A GLANCE

The final report of the Iowa Health Reform Council has been published and is available by contacting David Lyons at 515/281-5098.

A Wall Street Journal *editorial has called on Congress to remove fat from health system reform bills. Rep. Dan Rostenkowski (D-IL) has put a $580 million construction project for Chicago's Northwestern Memorial Hospital in the House Ways and Means Committee bill; other members have done the same.*

HealthTrends *says abortion is the "sleeping giant" in health system reform. About 30 House members say they can't vote for reform that includes abortion; 75 Democrats say they can't vote for reform that doesn't include abortion coverage. An option allowing providers and insurers to opt out of abortion coverage is the expected compromise.*

Futures program underway

The Iowa Medical Society's Futures program begins this month with a series of five regional meetings. ***Futures*** was initiated to help Iowa physicians plan for a future made uncertain by the growth of organized delivery systems and national reform initiatives.

See the accompanying page for details.

Governor's transition team meets

The Iowa Health Reform Transition Team, an offshoot of the Governor's Health Reform Council, held meetings in July and August to discuss health system reform developments in Iowa. Dr. William Eversmann, past IMS president, represents IMS on the transition team. The team is chaired by former Iowa Insurance Commissioner David Lyons.

Issues being discussed by the team include CHMIS implementation, standard benefit packages, practice parameters and consumer education. The team continues communication with the Iowa congressional delegation regarding Iowa's Medicare and Medicaid funding and other issues in national reform.

Press conference sparks controversy

Members of the AMA House of Delegates have received letters signed by 58 members of the House of Representatives who are critical of the AMA's joint participation with the AFL-CIO and AARP in a news conference on health system reform. At the press conference, the three groups urged Congress to pass a reform bill that achieves universal coverage, assures patient choice and slows health care spending.

Physicians in Florida, Texas and Georgia have also been critical of the AMA's action.

The AMA called the letter from the 58 House members "an attempt to undermine AMA leadership." According to AMA, the letter "incorrectly said the news conference endorsed the Clinton-Gephardt government run health care bill." AMA officials say the campaign was organized by Rep. John Linder and Newt Gingrich, two Georgia Democrats.

Meanwhile, members of the AMA House of Delegates and presidents and executives of state medical and specialty societies have been sent a memo from the AMA explaining participation in the press conference. The letter states that the AMA "has not altered its position on key aspects of health system reform. Voice, choice and universal coverage remain the focus of AMA advocacy efforts."

The letter called for "efforts to let Republican officials know the AMA has not changed its policy and will continue to pursue non-partisan health system reform."

Public confidence eroding, say polls

Public confidence that Congress will pass health reform this year is eroding, according to several recent polls. A majority of Americans disapprove of the health system reform performance of both Congress and President Clinton.

Position of 'non-support'

The AMA Board has taken a position of "non-support" for the House Democratic leadership health system reform bill. While the bill contains major portions of the AMA's Patient Protection Act, the AMA says the bill "needs significant improvement before physicians can support it."

The AMA voiced support for portions of the bill which call for health insurance reform and health IRAs but expressed strong opposition to the portion of the bill calling for a new governmental "Medicare Part C" system and proposed cuts in Medicare funding. The bill also contains no cap on non-economic damages as part of liability reform and no antitrust relief.

The AMA Board also voted to oppose all single payer bills now in Congress. IM

Ted Koppel and Tom Brokaw don't see it, but you do

While the media covers endless debate in Congress and the White House, health system reform has already started

---

Do you have a plan for the future of your practice? The Iowa Medical Society's new program can help you explore your options

FUTURES
Strategies for tomorrow's practice©

Futures will begin with five September regional meetings open to any Iowa physician (schedule below). The next steps will be a statewide conference "Organizing for Change" on Thursday, October 27 in Des Moines and small group presentations for any IMS member needing information about future practice options. At the regional meetings, IMS representatives will meet with and listen to Iowa physicians as they discuss what is happening in their areas. The statewide conference will focus on ways to cope with the new environment and plan for the future. Expert consultants will offer advice on evaluating and negotiating contracts in Iowa, financing arrangements and other key issues. Dr. James Todd, AMA executive vice president, will be the keynote luncheon speaker. For additional details, look on page 389 of this month's *Iowa Medicine.*

Registration form • Statewide Futures program

YES

I will attend the Iowa Medical Society's conference "Organizing for Change"
Thursday, October 27, 8:30 a.m. - 4:30 p.m.
Marriott Hotel, Des Moines
REGISTRATION FEE: $80 for members
(Includes lunch) $125 for nonmembers

Name _____ IMS member? Yes ____ No ____

Address _____

City _____ Zip _____

Phone _____ Fax _____

Clip out and mail to the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 ATTN: Barbara Cannon. A check for your registration fee must be enclosed. Registration Deadline: October 18. If you want to stay the night, please reserve your room directly with the Marriott Hotel, 515/245-5500.

REGIONAL MEETING SCHEDULE
These meetings are free and there is no pre-registration. All meetings will be held from 7 p.m. to 9 p.m.

1. **Storm Lake:** Mon. Sept. 19
   Buena Vista College
2. **Marshalltown:** Thurs. Sept. 22
   Marshalltown Medical Center
3. **Dubuque:** Tues. Sept. 27
   Dubuque Inn
4. **Burlington:** Wed. Sept. 28
   Pizazz Best Western
5. **Atlantic:** Thurs. Sept. 29
   Atlantic Country Club

Legislative Affairs

AT A GLANCE

Prompted by the debate on health system reform, dozens of doctors were seeking U.S. congressional seats. Following the primaries, 18 physicians remain in the race for House and Senate seats.

The Kiplinger Newsletter *and other publications are predicting a bad year for incumbents. Many observers say Republicans have a shot at picking up 20-25 House seats and an outside chance to control the Senate, where Democrats lead 56-44. The average off-year loss for the party in power is 24 House and 3 Senate seats. This year, Whitewater hearings and congressional gridlock on health care are adding to public cynicism about elected officials,* Kiplinger *says.*

Are you registered to vote in this fall's important elections? Don't miss the voter registration insert in this Iowa Medicine.

Discussion of IMS legislative priorities

IMS priority issues for the 1995 Iowa Legislature will be discussed at a meeting of the IMS Committee on Legislation September 13 at IMS headquarters. The committee chairman is Kevin Cunningham, MD.

The committee will also discuss health system reform, CHMIS, telemedicine and other key issues.

Reimbursement for telemedicine

Reimbursement for medical services provided using telecommunications technology was discussed at a recent meeting of the Iowa Telemedicine Advisory Council.

Representatives of third party payers at the meeting said they would not recommend reimbursing for most telemedicine services until there is more data on whether such services are safe and effective. HCFA is reluctant to reimburse until the AMA has developed a policy on the issue.

Those at the meeting expressed the opinion that once data is available, reimbursement concerns could be solved rather quickly. However, there are complex issues involved (for example, whether to reimburse two physicians for a video consultation).

It was noted that reimbursement for telemedicine is very appropriate for areas such as radiology and pathology. Other services such as those requiring the sense of touch will probably never be provided (or reimbursed) using telecommunications.

The council decided to recommend the Iowa Insurance Division study reimbursement in cooperation with third party payers and appropriate provider organizations.

Payers emphasized that support for reimbursement of telemedicine services by providers is essential. Lack of such support was one reason Georgia's Medicare reimbursement for telemedicine services was withdrawn.

Proposed prescribing rule causes concern

The IMS has provided comments to the Board of Nursing on proposed rules relating to advanced registered nurse practitioners (ARNP). The new rules were prompted by passage of legislation in 1994 (SF 2053) extending prescribing authority to nurse anesthetists and allowing all nurse practitioners to prescribe controlled substances.

The IMS has several major concerns with the proposed rules:

- The Board of Nursing did not follow a requirement that the rules be developed in consultation with the Board of Medical Examiners and the Board of Pharmacy Examiners. Participation in the rulemaking process by health care professionals with training and experience with prescription drugs is an important patient safeguard.
- The proposed rules remove the long-standing provision that ARNPs work as part of an interdisciplinary team according to protocols collaboratively developed by a physician and the ARNP. Removal of this requirement is contrary to the understanding legislators had in passing SF 2053 and has ramifications extending beyond rules regulating the prescribing of controlled substances by ARNPs.

The proposed rules have not yet been adopted by the Board of Nursing and must be reviewed by the legislature's Administrative Rules Review Committee. The Board of Medical Examiners, Board of Pharmacy Examiners and the Iowa Osteopathic Medical Association have also submitted comments voicing their concerns with the rules.

The IMS has recommended the rulemaking process be deferred until the Board of Nursing has been able to work in cooperation with the Board of Medical Examiners and Board of Pharmacy Examiners in preparing a new draft of rules and that the new rules incorporate the existing concept of practice by ARNPs as part of an interdisciplinary team under protocol developed with a physician.

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An interview with Greg Ganske



Editor's note: Dr. Greg Ganske, a Des Moines plastic surgeon, is making a bid for the 4th congressional seat held by Neal Smith. He is pictured above with his campaign vehicle, a 1958 DeSoto.

Why are you running for the U.S. Congress?

I want to help solve our country's problems. I am concerned about the loss of values that made our country great, the breakdown of the family and the declining quality of life. I am also concerned about our huge national debt. I don't want my children to have a mortaged future.

What issues concern you the most?

Welfare reform should be a top priority. We need welfare reform that offers a helping hand but requires responsibility from the recipients. All able-bodied adults should work. Also, we must get a handle on government spending. When Neal Smith was elected to Congress in 1958, the average family in the 4th Congressional District was sending 10% of their income to Washington for taxes. Today, it is over 25%. The problem is career politicians who have spent $1.35 for every $1 of revenue. As a surgeon, I am paid to make tough decisions. Congressmen should also be required to make tough decisions on cutting government spending.

I also believe we need campaign finance reform and term limits.

What approach to health system reform do you favor?

I would work for common sense solutions to the problems of cost and security. We need insurance regulatory reform to address the issues of portability and preexisting conditions. Individuals should be able to get the same tax deductions available to workers for large corporations. We need tort reform to decrease costs. I favor tax vouchers and/or credits to help the "working poor" get insurance. I also believe we need to look at changes in the antitrust laws.

In my opinion, bills which emphasize employer mandates, price controls and large bureaucracies are not the answer. My opponent, Neal Smith, is a cosponsor of the Clinton plan, which is funded mainly from $165 billion in Medicare cuts. This would be particularly harmful to rural hospitals and practitioners.

How has the medical community responded to your candidacy?

I've been gratified by the support of medical friends and colleagues throughout the 4th Congressional District. I enjoy practicing medicine and, if I'm elected, I will ensure I do not lose my surgical skills. I believe people should serve in Congress for a limited time and return to their professions.

How do you view your chances of unseating a 36-year incumbent?

With help from friends, I have a good chance of winning. I won the Republican primary by 78% and a recent poll by one of the nation's leading pollsters shows I am leading in this race. My opponent is accurately perceived as a tax-and-spend pork barrel career politician. He will have a hard time defending his 36-year record on issues such as crime, health care and the national debt. IM

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Medical Economics

Anti-dumping provisions

The Department of Inspections and Appeals has been working with the Iowa Hospital Association to educate members about the requirements of anti-dumping provisions in the Social Security Act.

An area which affects physicians in the emergency room is use of physician assistants to provide on-call coverage. The Social Security Act requires a hospital to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency condition. A physician assistant does not meet the definition of a physician under this section.

For more information, contact Nancy Ruzicka at the Dept. of Inspections and Appeals, 515/281-4120.

Vaccines For Children program

The AMA and other provider groups have been working with the Centers for Disease Control to increase physician participation in the Vaccines For Children program. The federal government will make $400 million available this year to buy vaccines for children up to 18 years old. Vaccines will be provided to private physicians enrolling in the program; enrollment begins October 1. You will receive more information about this program in the near future. For the latest information, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

MinnesotaCare tax challenge

The Minnesota Supreme Court has unanimously reinstated the physician challenge to the MinnesotaCare tax on health care providers who live and practice outside of Minnesota but treat Minnesota patients. The tax was effective as of January 1, 1994 and affects Iowa physicians.

The Iowa Medical Society and state medical societies in other contiguous states are supporting lawsuits on behalf of physicians who live outside Minnesota but treat patients from Minnesota. The lawsuit challenges the constitutionality of applying the tax to out-of-state providers. Last winter, the court interpreted the statute to prevent physicians from suing until the state assesses the tax. That decision was appealed and has now been reversed. The case now returns to trial court for a ruling on the constitutional claims.

Medicaid managed care expansion

Expansion of the Iowa Medicaid Managed Health Care program continues. At least 75 Iowa counties now participate in the Medicaid Patient Access to Service System (MediPASS). Almost 1,300 primary care physicians participate in the program; over 100,000 Medicaid recipients are enrolled. MediPASS is one of the largest Medicaid managed health care systems in the Midwest.

Unisys Corporation, which manages the Iowa MediPASS program, now publishes a newsletter for recipients called *HealthTracks*.

Committee on Medical Service to meet

The IMS Committee on Medical Service will meet September 22 to discuss the Community Health Management Information System (CHMIS) and telemedicine. Programs currently being impemented by third party entities will also be on the discussion agenda.

The Committee on Medical Service, which contains representatives of specialty societies, is a forum through which third party payers, government entities and others provide information to physicians.

AMA, state societies win appeal

More than 300 physicians will not have to repay Medicare for $2 million in alleged laboratory overpayments. A Medicare fair hearing officer ruled recently in favor of the physi-

continued

AT A GLANCE

A report in the American Journal of Pubic Health *says that smoking bans in restaurants do not hurt business. Researchers have compared sales in 15 California and Colorado cities that have smoking bans with sales in 15 similar cities without bans.*

The AMA wants to make health plans and third party payers legally liable for requiring physicians to use clinical practice guidelines. New language was adopted at the AMA's House of Delegates meeting stating that "third party payers should be assigned liability arising from requiring participating physicians to adhere to a specific set of practice parameters."

Medical Economics

continued

cians; the ruling cannot be appealed.

Pennsylvania Blue Shield, which processes Medicare claims in several mid-Atlantic states, failed to implement a directive from Medicare with respect to payment for lab services. Because of the error, PBS allegedly overpaid physicians $13 million during a three-year period. However, after negotiations with the AMA, HCFA decided to seek repayment only for the most recent year.

The AMA argued at the hearing that the physicians were not at fault because they followed the PBS directions on billing for lab services.

Under the ruling, Blue Shield must repay to the physicians any funds already collected as overpayments.

Medical cost hikes are slowing

Medical costs in the U.S. are rising at the lowest rate in two decades, new reports indicate. The AMA interprets this as "another sign that the health care industry is managing to bring expenses under control."

These findings are bolstered by large employers who say they are winning significant reductions in premiums from some health plans as they negotiate rates for 1995.

More physicians are employees

According to data from the AMA's Socioeconomic Monitoring System, the proportion of physicians who are employees increased from 23.4% in 1982 to 30.4% in 1993. On average, employed physicians work significantly fewer hours than self-employed physicians.

Prevention vs. cure

A new study of cost-benefits says in some cases, prevention is more costly than a cure.

The study was conducted by the Harvard School of Public Health Center for Risk Analysis. Among other things, the study says medical care generally saves lives at less cost than workplace safety or environmental measures and that extravagantly large sums are spent to alleviate minor cancer risks. IM

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

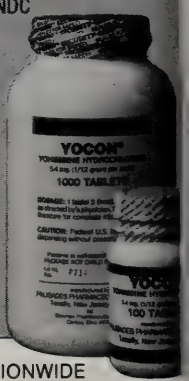
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Practice Management

Information and referral service

A new toll-free telephone information and referral service is available to physicians and their patients who have disabilities.

After a patient is diagnosed with a disabling condition, physicians are often asked about services available to them, including non-medical services. It would be cumbersome for physicians to keep information on all the support groups available, but this information is available by calling Iowa COMPASS.

The COMPASS number is 800/779-2001. Specialists are available to provide information about local, state and national agencies and organizations that provide a requested service. COMPASS maintains current information on over 9,000 agencies. A physician or staff member may call on behalf of a patient or offer the number to the patient.

Personal financial strategies

(This article was written by Jerry Foster, a certified financial planner with Retirement & Investment Advisors, Inc. It is the first of several parts.)

Given the current economic environment, it can be difficult to establish the proper strategy for accomplishing your personal financial objectives. There are three key elements to keep in mind: 1) proper planning; 2) maximizing tax benefits; and 3) discipline.

This article deals with planning, the element which requires the largest amount of time. Begin with a clear idea of your goals. For example, when do you plan to retire? What is your income objective? What expenses do you need to prepare for? What projected rate of inflation is realistic?

Next, increase your knowledge of your assets. What retirement plans do you have? Are you or your spouse earning self-employed income? (There are opportunities for those who earn self-employed income which are not available to salaried employees.) Can you create savings plans on your own?

Finally, develop an awareness of investment planning strategies. Recognize there are different types of asset "classes" — for example, cash, debt (bonds), equity (stocks) or real estate. Achieving a balance among these asset classes will help you minimize your risk.

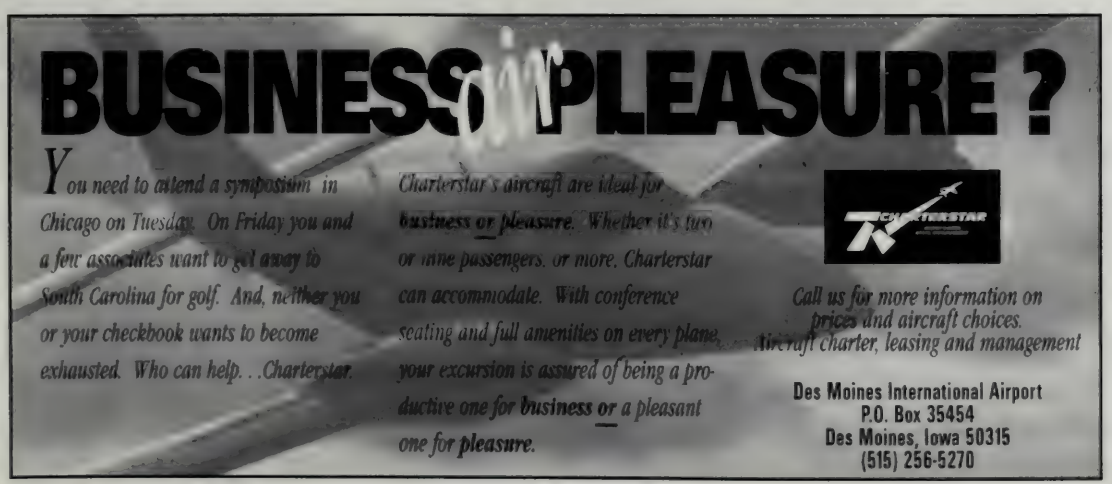
Once asset classes are recognized, be aware of factors that result in total investment portfolio performance. These are 1) asset class selection; 2) individual product choice and; 3) investment timing decisions. Most people spend their time deciding which investment product to purchase or when to make an investment.

In actuality, choosing an asset class is substantially more important than choosing an investment.

AT A GLANCE

The IMS has available a complete list of magazines which do not accept tobacco advertising. To get the list, call Chris Clark at IMS headquarters, 800/747-3070 or 515/223-1401.

Want to help ensure your first-class mail gets there on time? Check the address and the zip code, be as precise as you can with the address and type the address (handwritten mail is hand sorted). If you have a computer, use a program that prints the bar code on the letter and use white or pale-colored envelopes which are easier for the machines to read.



Practice Management

continued

Defense of 35-40% of all malpractice claims is jeopardized by problems with medical records.

Midwest Medical Insurance Company Focus on Risk

Are liability risks lurking in your office?

Failures in clinic risk management systems continue to be a major cause of patient injuries, malpractice claims and expensive claim losses. They can be as obvious as inadequate documentation or as subtle as poor patient relations. Many preventable malpractice claims arise or are lost because of problems in these areas:

•**Patient reactions** — Plaintiff attorneys estimate that 70-80% of patients who see an attorney to file a claim do so because they are angry because of a breakdown in communication, long waits or other non-medical factors that are perceived as lack of care, concern or respect for patients.

•**Medical records** — The quality of a medical record is critical in preventing and controlling patient injuries and malpractice losses. Deficiencies in documentation can have significant consequences in causing patient injuries, filing of malpractice claims and defense of claims. Experts estimate the defense of 35-40% of all malpractice claims is jeopardized by problems with medical records.

•**Follow-up** — The cause of many injuries and claims is the failure of physicians and clinics to follow up on important clinical information. A common cause of patient injuries is routine filing of lab, x-ray or other reports before they have been reviewed by the physician.

A risk management survey by MMIC consultants can help identify potential liability exposure and offer advice that can prevent injuries and claims.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

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Are you registered to vote?

"Like no other time in recent history, all physicians must be involved in the political process. We have an opportunity to vote this coming November and in that way express our opinion on the efforts of our leaders. One vote can make a difference, sometimes dramatically. Get prepared to vote. Register now!"

James White, MD, president
Iowa Medical Society

One of the great myths about voter registration is that some people think they are more likely to be called to jury duty if they are registered to vote. This is not true. You are more likely to be called for jury duty for getting a driver's license than for being registered to vote.

Need more voter registration cards? Call your county commissioner of elections in the county auditor's office. Or contact a local IMS Alliance member. The Alliance is launching a voter registration drive to make sure all eligible physicians and family members are registered to vote.

INSTRUCTIONS

1. Use this form to register to vote, or to report a change of name, address, telephone number or party affiliation. Please check the appropriate box(es) at the top right. If you are not certain you are presently registered in the county in which you live, check the "new registration" box.
2. The following information is required:
   a. Your full name.
   b. Your birth date.
   c. Your complete address, including apartment and box numbers.
   d. Your gender.
   e. The name of the county in which you live.
   f. Where you were last registered to vote.
   g. Your signature.
3. The following information is requested:
   a. Your social security number. Solicited pursuant to Iowa Code Section 48.5, this number is used to avoid multiple registrations for a single individual.
   b. The name of the city and school district in which you live. If you do not live inside a city, list the name of the township and section number in which you live. If you do not know your township and section number, complete the "RURAL ROUTES" section on the reverse side of the form.
   c. Your telephone number, including area code.
4. Detach this stub before mailing the form.

(More information other side.)

Fill out the card below, cut it out and mail in an envelope to:

County Auditor—Commissioner of Elections
Courthouse
_____(your county seat)
Iowa _____ (zip code)

ALTERNATE REGISTRATION FORM
Please see instructions at left.

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CHECK ALL THAT APPLY:
☐ This is a new registration in this county.
This is a change of ☐ Name ☐ Address ☐ Telephone ☐ Party

_____ - _____ - _____	Month Day Year _____ ___ ___	Female ☐ Male ☐	( )	Democratic ☐ Republican ☐
Soc. Sec. No. (If available)	Birth Date	Gender	Telephone	Party

NAME: _____
Last First and Middle

ADDRESS: _____
House number & street (or rural route) plus apartment & box number

_____
City, State, and Zip Code

PREVIOUS REGISTRATION INFORMATION: I was previously registered to vote in

_____
(City, State, Zip Code; County if known.)

My name then was _____

I certify that I am a citizen of the United States, that I am or will be an eligible elector at any election at which I attempt to vote and that all of the information I have given upon this voter registration form is true. I authorize cancellation of any prior registration to vote in this or any other jurisdiction and my eligibility to vote in any jurisdiction where voter registration is not required. I am aware that fraudulently registering, or attempting to do so, is an aggravated misdemeanor under Iowa law.

_____
Signature Date

COMPLETE ALL YOU KNOW

COUNTY NAME: _____

SCHOOL DISTRICT: _____

CITY (If inside limits): _____

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Registration date: _____

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Form 2E (Rev. 88) CFN-337-5005 CPF-66929

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PLEASE COMPLETE THIS SECTION ONLY IF YOU LIVE OUTSIDE THE CITY LIMITS OF ANY CITY, AND YOU DO NOT KNOW THE TOWNSHIP AND SECTION NUMBER IN WHICH YOU LIVE.

Please do not attempt to provide directions to get to the location, but instead describe where it is.

I live _____ miles _____
number N,S,E or W

and _____ miles _____ of
number N,S,E or W

_____
landmark or highway junction

County Auditor — Commissioner of Elections

Courthouse

_____
City (County Seat)

IOWA _____
Zip Code

MORE INFORMATION

1. To register to vote, you must be a citizen of the United States, at least 17 1/2 years old, and declare Iowa as your voting residence. (You must be at least 18 years old to vote.)

2. This form must be received by your County Auditor by the 10th day preceding a primary or general election, or by the 11th day preceding any other election, or postmarked by the 15th day preceding any election to be valid for that election.

3. You should receive a receipt of this registration within 10 days. If you do not, please contact your County Auditor. Be prepared to state when and where you filled out the form, and to whom it was given or sent if you did not personally mail or take it to the Auditor.

4. There are other ways to register. Contact your County Auditor if you need assistance.

Newsmakers

Clarification

Dear Editor:

In the Newsmakers section of your July 1994 edition of *Iowa Medicine* you note that "Dr. Jeffrey Boyd has joined the McFarland Clinic in Ames. Dr. Boyd is a cardiologist who previously practiced at the Iowa Heart Center, Des Moines."

More accurately, Dr. Boyd is still associated with the Iowa Heart Center, although he is now practicing at the McFarland Clinic in Ames. He is one of several Iowa Heart Center cardiologists seeing patients at McFarland Clinic (the others are Dr. Kevin Crowe and Dr. Thomas Edel).—*Bill Maurer, Des Moines.*

Letter to the Editor

Awards, appointments, etc.

Dr. Ratnam Mullapudi, a Dubuque cardiovascular and thoracic surgeon, is training in pediatric cardiac surgery at the Heart Institute in Sao Paulo, Brazil. Dr. Mullapudi and his wife, **Dr. Nalini Mullapudi** plan to relocate to a new hospital in Bombay, India in early 1995. **Dr. Stephen Pierotti,** Dubuque general and orthopaedic surgeon, has joined the Finley Hospital staff and **Drs. Julian Nemmers, Gerald Meester** and **James Pearson** in practice. Dr. Pierotti received the MD degree from the U. of I. College of Medicine and completed an internship and residency program through Ohio State University. **Dr. John Floyd, Jr.** has been elected president of the Linn County Medical Society. Dr. Floyd practices with Cedar Rapids Radiologists, PC. He suceeds **Dr. Mary Anne Nelson,** a family practitioner and will serve a one-year term. Other new Linn County Medical Society officers are **Dr. Steven Eyanson,** rheumatology and internal medicine, president-elect; **Dr. Wilson Strong,** general and thoracic surgery, vice president; and **Dr. Thomas Hansen,** pediatrics, secretary-treasurer. **Dr. Joseph Jenkins,** general surgery, has joined the Dubuque Finley Hospital staff and **Drs. David Oppert** and **Keith Shaw** in practice. Dr. Jenkins received the MD degree from the UI College of Medicine and completed an internship at Walter Reed Army Medical Center in Washington and a residency at the University of Iowa. **Dr. Dean Gesme** of Oncology Associates in Cedar Rapids travelled to Russia with the Iowa-Stavropol medical exchange program. This was the ninth exchange visit since the program began in May 1993. Among other objectives of this visit was the development of continuing education programs with Russian oncologists. **Dr. Albert Coates,** Cedar Rapids orthopaedic surgeon, has been named to the board of directors of the Mid-Central States Orthopaedic Society. **Dr. N.K. Pandeya,** Des Moines plastic surgeon, has been awarded the Chief Flight Surgeon's designation by the Surgeon General of the United States Air Force. Colonel Pandeya is the first Iowa Air National Guard physician to attain this distinction. St. Luke's Hospital in Cedar Rapids and the Iowa Health System (IHS) in Des Moines plan to merge and create a new statewide health care delivery system. The IHS was created in 1993 when Iowa Methodist Medical Center and Iowa Lutheran Hospital merged. **Dr. John Hartmann,** Dubuque, recently became board certified by the American Osteopathic Board of Family Physicians. **Dr. Donald Heistad,** professor of internal medicine at the UI College of Medicine, has been named University of Iowa Foundation Distinguished Professor of Internal Medicine. Dr. Heistad is an internationally recognized leader in research on high blood pressure, atherosclerosis, stroke and cerebral circulation. He is deputy director of the UI Cardiovascular Research Center and co-director of the UI Center on Aging.

Deceased members

Frederick Loomis, MD, 81, life member, family practice, Waterloo, died April 19 IM

AT A GLANCE

A new program has been implemented by the IMS to help physicians ensure their practices are successful in the future. The program, called ***Futures,*** *has several components which are designed to help physicians explore their options and take control of their future. See pages 379 and 389 for more details on how this timely program can benefit you.*

The University (State) Hygienic Laboratory marks its 90th anniversary this year. The laboratory provides a variety of services to the state, including monitoring air quality, ground water, soil, rivers, lakes and streams. The laboratory's Bureau of Disease Control oversees testing and research in areas such as parasitology, immunology and bacteriology and offers the only full-service diagnostic virology laboratory in Iowa.

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FUTURES

Strategies for tomorrow's practice

Physicians don't need a crystal ball to see how much the practice of medicine is changing. Organized delivery systems are increasing and health system reform is likely to speed up this process. Many physicians are bewildered and frightened at the prospect of such radical change.

Some physicians may have already made a move toward integration and are wondering if they've chosen the right path or if they should change direction. In other words, no matter where you are today, is it where you want to be or where you should be?

Change offers opportunity. Having a plan for the future is the key to thriving in a new environment.

That's the idea behind the Iowa Medical Society's ***Futures*** program. The IMS wants to help you plan a strategy that will ensure the success of your practice. The program has several components, all of which are designed to help you explore your options and take control of your future.

Futures will begin with five regional programs in September open to any Iowa physician who wants to meet colleagues and discuss the changing practice environment. Next, there will be a statewide conference "Organizing for Change" on October 27. At this conference, expert consultants will offer their best strategies for tomorrow's practice and Dr. James Todd, the AMA's executive vice president, will discuss health system reform and other timely issues. (Complete details and a registration form for the statewide conference can be found on page 379.)

On the following pages you will find reprinted articles by expert consultants exploring some of the important issues you need to consider when planning for the future of your practice. Additional articles will appear in next month's *Iowa Medicine*.

INDEX OF ARTICLES

This month . . . When do you need to hire a consultant or attorney? • What are your options? • Pros and cons of practice models
• Forced into a corner — the psychology of integration

Next month . . . Experts write about how to get the most from a consultant after you have hired one, contract pitfalls and capitation payment

FUTURES

When should you hire a consultant?

NOTE: This article is taken from the *"Physician's Guide to Selecting and Working with a Managed Care Attorney or Consultant"* published by the American Medical Association. This guide is available free to AMA members by calling 800/621-8335, order number OP 631193MD.

Physicians may not understand there are alternatives such as a physician-driven venture that may better serve their interests.

Physicians seeking to prosper in this time of change need the assistance of legal and consulting experts. The need to seek the advise of legal counsel or a consultant may not always be apparent. These days, physicians are continually being presented with proposals or opportunities (such as joining a hospital's PHO) they may not understand. They may be asked to make decisions quickly. They may not understand there are alternatives such as physician-driven ventures that may better serve their interests.

It is critical that physicians ensure their interests are vigorously represented by an unbiased third party. The following scenarios illustrate only a few examples of when independent representation may be necessary.

- The Metropolitan Hospital System asks Dr Jones to participate in the design of a physician-hospital organization. Metropolitan proposes using a "neutral" attorney or consultant, which it will select and pay for, to represent all parties and assures Dr. Jones there is no need for additional advisers.

- The state passes a health reform bill requiring Medicaid beneficiaries and all state employees to receive care through approved managed care plans. The Downtown Medical Group, a group practice serving a significant number of state employees, wants to know how it can be assured that its patients will continue to be able to receive health care services from the group.

- A hospital decides to become an "at risk" managed care subcontractor to a major HMO. The hospital will contract with other hospitals and with physicians. A specialist physician is provided with general information and some draft contracts at a general meeting. The specialist seeks to understand the relationships and the potential role he or she is expected to play in the organization.

- The Indemnity Insurance Company asks the Northside Clinic to participate in the design and development of a strategic alliance or "risk agreement". Indemnity proposes using its in-house attorney to represent both parties.

- The Good Care HMO decides to reduce its provider panel by half by not renewing the contracts of several physicians without citing a cause. The terminated physicians want to know how to prevent this from happening in the future.

- Two groups of cardiologists who have competed through different hospital affiliations are approached independently by HMOs to capitate specialty services. Looking to the future, the groups consider merging their practices for managed care contracting.

- The Lakeshore Medical Clinic is approached by the Countryside Physicians Group, which proposes a merger. To work out the details, Countryside proposes using a "neutral" attorney or consultant it has identified and will pay for.

- Community Hospital informs its medical staff members that they must sell their practices to the hospital and become employees if they wish to continue providing care at Community.

- The East Suburban Hospital System proposes to purchase all the tangible and intangible assets of ABC Associates, a physician group. East Suburban proposes using its "neutral" corporate counsel.

- The Neurosurgery Associates Group is approached by the Springfield Medical Center, which proposes development of a physician/hospital shared risk pool applicable to all risk agreements entered into by the two organizations. The medical center suggests using its attorney to represent all parties.

Given the proper advice, physicians can take the lead and control their professional destinies. Given inappropriate advice, physicians risk losing the investment they have made in an advisor and something far more valuable — opportunities and options that may not be available in the future. In next month's Iowa Medicine, *Tom Gorey of Policy Planning Associates in Chicago, discusses how to effectively manage a consultant or attorney after you have hired one.*

Next month, Chicago consultant Tom Gorey discusses how to effectively manage a consultant after you have hired one.

FUTURES

What are your options?

NOTE: This article is excerpted from an article by Tom Gorey of Physician • Hospital Services, Inc. in Lakewood, Illinois.

Due to demands from payers, opportunities for managed care contracting are mushrooming.

The growth of managed care is having a profound effect on health care delivery in Iowa. In this new environment, several options merit your consideration. The multispecialty group is a partnership or corporate structure through which physicians from various specialties combine interests and share the profits and expenses of a practice. Other viable options are shared office arrangements, an Independent Practice Association (IPA), a "group without walls" and single specialty groups.

A large, well-structured multispecialty group has considerable potential for taking advantage of managed care contracting. In addition, physicians in these arrangements can provide a comprehensive array of medical services and are in a position to accept capitation payment. **(Capitation payment is a method of payment for health care services in which the provider accepts a fixed amount of payment per subscriber, per period of time, in exchange for specified services over a limited time period.)**

Shared office space and other arrangements are a way for solo practitioners to reduce overhead and take a step toward group practice. However, they do little to promote practice development. Due to demands from payers, opportunities for managed care contracting are mushrooming. To take advantage of these, physicians may wish to consider an **Independent Practice Association (IPA)**. Through an IPA, physicians can take advantage of opportunities to build their patient base through participation in managed care contracts.

A relatively new phenomenon is the **group practice without walls**. The group without walls incorporates some characteristics of a traditional IPA with the added component of shared management and administrative services. The group may be marketed under a single name with physicians sharing administrative expenses while retaining their own revenues. Each participant maintains their own practice space.

Another option is formation of a **Physician Organization (PO)**. A PO can be an effective defense against "divide and conquer" strategies by payers and hospitals. A PO should be the first step toward entering into a **Physician-Hospital Organization (PHO)** agreement with a hospital as it can serve as a vehicle for providing physician input into the governance of the PHO.

However, forming a PO involves significant antitrust risks. The entity being created must have a legitimate business purpose, the physicians must be at financial risk and the entity cannot be created merely as a sham to engage in price-fixing. Formation of an IPA-type PO is one way to minimize potential legal problems.

In This Issue: How CHMIS Will Help Improve Quality of Care

Advancing Iowa Health Care

Iowans Working for a Stronger Health Care Future • Spring/Summer, 1994

New Technology Offers New Resources and Eases Administrative Burden for Physicians and Other Providers

You've heard it called "The Hassle Factor." It's no secret that today's health care delivery system poses a huge administrative burden for physicians and other providers who must respond to the paperwork requirements of hundreds of insurance companies and other agencies.

Because there is no uniformity in the information requirements of insurers and payers, physicians and other providers are forced to employ proportionately large administrative staffs whose job it is to fill out the forms. In the current system, this is an essential part of the claims and payment process — physicians and other providers are not compensated for the services they render until the paperwork has been processed. All this work increases the cost of health care services — without improving the quality of care for consumers.

The Community Health Management Information System (CHMIS) currently under development in Iowa attacks this expensive problem on two levels: It simplifies the paperwork, and speeds up the information process. All physicians and other providers would submit essential treatment and claims data via a single electronic format -- a major improvement for a provider who may today handle as many as 400 separate paper forms. To speed up the process, this data would be entered into a computer at a convenient physician or other provider origination point, then transmitted electronically to the destination. Electronic data transmission would significantly reduce the amount of time required to process a claim through the system, eliminate postal delays, and facilitate prompt communication if problems arise. The result is that less work is required to generate claims, and claims are handled faster.

Another significant administrative concern impedes our ability to improve quality of patient care in Iowa: Our current health care information resources are inadequate. With all the health care paperwork we now generate, it seems logical that one resulting benefit would be a rich information storehouse of data — a potentially invaluable resource for practitioners and researchers. Unfortunately, that is not the case at present.

Today, lack of information standardization on the origination end makes it difficult or impossible for physicians or other providers to analyze the claims data they submit. For all their paperwork, physicians and other providers do not have access to compiled information that could be used to study results of treatment, leading to improvements in the quality of our health care.

The Iowa CHMIS offers a solution. Its centralized data repository would assemble and store information collected by the transaction system from physicians and other providers and through special studies. This information would be available to interested, qualified users in a form which protects patient confidentiality. Physicians and other providers, business, government and consumers will be able to use this information to define health care value — the best quality at the best price.

In an age when high tech is everywhere, it may surprise you to know that the system used to transmit health care treatment and payment information among physicians and other players in the health care delivery system isn't nearly as up-to-date as the one you tap into whenever you use your bank card.

In fact, experts say that outdated, inefficient information processing is one of the most important problems to address in health care reform. An electronic information network would reduce a huge paperwork hassle, cut costs, and create an information resource to help us determine which medical treatments work best.

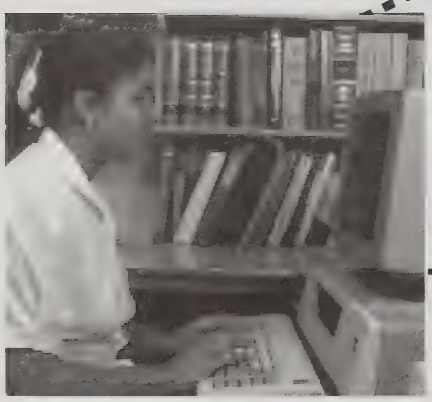
In Iowa, work to develop an up-to-date Community Health Management Information System (CHMIS) came about through an initiative funded by the Hartford Foundation in New York. Here's an update on the Iowa CHMIS group's unique plan to bring our health care system into the information age.

**For more information, contact Sheila Gregan at Health Management Information Center,
Two Ruan Center, Suite 330 601 Locust Street
Des Moines, Iowa 50309 - 3772. Phone (515) 243-6441.**

Questions and Answers:

Building a Community Health Management Information System for Iowa





How did the idea for CHMIS get started?

The CHMIS concept was created by the John A. Hartford Foundation for two reasons: to meet a community's shared needs for health care data, and to facilitate the transactions and communications associated with health care through computer-based technology.

The Hartford Foundation is a charitable organization, established in 1929 by members of the family that started the A&P grocery stores. The Foundation is not connected with the insurance industry. Neither the Foundation nor its contractors has any commercial interest in CHMIS. The Foundation devotes earnings from its nearly $300 million endowment to help improve our nation's health care system through projects such as CHMIS.

How did CHMIS originate in Iowa?

The 1992 Iowa General Assembly directed the Iowa Health Data Commission (IHDC) to study the feasibility of two important and related concepts: (1) A statewide electronic network to transmit all claims payable information from providers to third party payers and (2) Use of this network as the foundation of a state-wide health data repository.

Communication between those pursuing the state of Iowa's request and the Health Policy Corporation of Iowa (HPCI), recipient of a Hartford Foundation grant to develop a statewide Community Health Management Information System (CHMIS), was coordinated by the Health Management Information Center (HMIC). (HMIC is the IHDC's data contractor and an HPCI subsidiary.) Early on, participants committed to an inclusive process: CHMIS committees and work groups have included representatives of every sector of the health care delivery system, including consumers, physicians and other providers, business government, and payors.

The IHDC feasibility study submitted to the General Assembly in January, 1993, concluded that a

How much will CHMIS cost, and who will pay for it?

The exact cost of CHMIS and the most workable financing mechanism cannot be determined until further decisions are made by the Governing Board. A transfer fee (from the network to the data repository), membership fees, and user fees are expected to go toward funding the repository.

It is likely that up-front financing be provided by the private sector through a vendor RFP (request for proposal) process.

The Iowa CHMIS Time Line

1993

Iowa General Assembly reviews CHMIS study.

1994

Bill authorizes CHMIS implementation.

1995

General Assembly expects p

tatewide CHMIS was both technologically and politically easible in Iowa. According to the study, the CHMIS concept as a good fit with the current environment of health care eform efforts occurring at the national, state and community evels. The need for full support from all the stakeholder roups was noted. To allow continued research and education, phased-in approach to CHMIS implementation was sug-ested.

The Steering Committee continued in an ongoing role. n cooperation with its work groups on Governance/Finance, Data Advisory and Technical Design, implementation issues were defined. Members of the Committee served as the Management Information subcommittee of the 1993 Iowa Health Care Reform Project. Legislation authorizing CHMIS development was passed early in 1994.

How will the Iowa CHMIS fit in with the Iowa Health Data Commission?

Since it was founded in 1982, the Iowa Health Data Commission has been known nationally as a pioneer in the creation of a system to collect and disseminate clinical and administrative health care data. This work has laid a strong foundation on which the CHMIS can build.

The CHMIS approach is an evolutionary expansion of the concept which started the IHDC, and is its natural successor. To ensure that data collection continues uninterrupted during the transition from IHDC to CHMIS, CHMIS requested that IHDC operations continue until CHMIS is fully operational. The bill passed by the Iowa General Assembly extends the IHDC through July 1, 1996.

How would an Iowa CHMIS improve the quality of our health care?

Quality improvement requires reliable information about the processes and systems which are part of the area under study. In the field of health care, for example, data connecting treatments and outcomes enables researchers to determine what works, and what doesn't work. Data collected via CHMIS could be used in these applications:

Provider Resource Studies evaluate the supply of hospital and physician resources, and are essential considerations in the health policy debate.

Outcomes Studies enable researchers to evaluate the effectiveness of various medical and surgical treatments.

Quality Studies describe patient satisfaction and functional status, allowing consumer input.

Community Profiles enable closer study of physician and hospital services.

Small Area Studies identify geographic areas in which practitioner utilization patterns vary significantly.

Provider Profiling enables providers to compare the difference between their own practice patterns and the patterns of peers.

Who will run the CHMIS?

CHMIS will be run by a Governing Board, a voluntary, nonprofit entity whose members have been appointed by the Governor of Iowa. The Governing Board will be held accountable for successfully implementing the CHMIS mission, and will be responsible for determining necessary staff support. CHMIS will be regulated by the Iowa Division of Insurance.

The Board consists of two individuals representing hospitals, two individuals representing physicians, two individuals representing payors other than a self-insured plan, and six individuals representing consumers of which at least two individuals shall represent employment-based purchasers representing non governmental entities purchasing group health plans on behalf of other individuals. Additionally, at least one of the individuals representing employment-based purchasers shall represent self-insured plans.

The CHMIS Mission Statement

To establish, in concert with state and national health data and health care initiatives, an integrated electronic health management system for the state of Iowa that will be responsive to the changing needs of all Iowans by:

•Reducing the cost, improving the efficiency, and simplifying the processing of claims and payment transactions;

•Providing an efficient system to share information on appropriateness, efficiency and effectiveness of health care services to improve the quality of health care for Iowans;

•Providing data for research; and

•Supplying information for educational purposes to enhance the health status of Iowans.

How will implementation of the Iowa CHMIS take place?

The CHMIS will be activated in a phased manner, in order to allow system architects time for continuing research and users time for education and orientation. Here's a review of the three phases:

Phase I: Target date July 1, 1996

At the time when Phase I is fully operational, physicians and other providers will submit claims electronically in a common format via phone lines, using personal computers located in their offices.

Physicians would choose a network that automatically directs the claim to the correct payer. Remittance and patient eligibility information will be transmitted in this same manner. For capitated payments, encounter information (including diagnosis and procedure codes, but not charges) would be sent.

All third party payors would be required to use the same uniform billing format. So that physicians could submit claims information to only one network, insurance companies would be required to participate in networks.

Phase II: Target date July 1, 1999

When Phase II is fully operational, physicians and other providers using the CHMIS to transmit information would increase the amount of information submitted through the network. Phase II additions would include information about lab tests, x-ray results, inpatient pharmacy codes and aggregate data sets indicating clinical performance.

Continued on page 4

1996 CHMIS Phase I

1999 CHMIS Phase II

Future CHMIS Phase III

Continued from page 3

How much money will CHMIS save?

To estimate CHMIS cost savings, the Steering Committee evaluated pilot research conducted by the Work group for Electronic Data Interchange (WEDI), a voluntary public private task force established in 1991 to help reduce health care administrative costs.

WEDI research demonstrated an electronic per claim savings over the current system: $1.07 for physicians, $1.01 for hospitals, and $.73 for payers. The WEDI study also revealed savings from electronic benefits inquiry, claims inquiry, eligibility and remittance advice — services which will be added as the CHMIS is phased in.

How will confidential patient information be protected?

Both the CHMIS Steering Committee and many stakeholder groups have expressed concern about the need to protect patient-specific information. Extensive research on this issue has already been completed, and will continue to ensure that state-of-the-art safeguards are in place. These mechanisms include:

- security codes
- passwords
- transaction verification
- documented security guidelines
- confidentiality agreements
- a disaster recovery plan
- facility security
- telecommunications monitoring
- audits
- research protocols

What's the best way to find out more about CHMIS?

Members of the CHMIS Steering Committee, work groups, and project staff members are available to answer questions and make updated presentations to interested individuals or groups. To get more information, contact Sheila Gregan at the Health Management Information Center office by calling (515) 243-6441.

Excerpts from The CHMIS Bill.

"The General Assembly finds that the development of a community health management information system will result in a more efficient and cost-effective health care transaction process; provide an efficient mechanism for the exchange of medical and transactional information among providers and other interested entities; provide communities with information on cost, appropriateness, and effectiveness of health care providers; and provide information to employers and researchers which will allow for benefit plan analysis, severity of illness and outcomes analysis, and related studies.

"The general assembly finds that the exchange of such medical and transactional information, while vital in the effort to control health care administrative costs and in analyzing benefit plans and medical outcomes, must be accomplished in a manner which protects and assures patient confidentiality; that authorized users of the system must keep such information confidential; and that the privacy rights of individuals must not be violated as a result of the exchange of such information.

"The general assembly also finds that the implementation of such a system will result in a reduction of the number of paper transaction forms that need to be completed, a reduction in the error rate on transaction submissions, an improvement in the overall data communication among affected parties, and a reduction in health care administrative costs.

"The general assembly also finds that there shall be only a single community health management information system in this state."

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What are the pros and cons?

Independent Practice Association

Independently practicing physicians organized to contract with an HMO.

PROS

•Vehicle for MD participation in true managed care risk contracting.

•Low capitation needs, low-risk model.

•Participating MDs maintain professional and financial autonomy and independent legal status.

•Potential access to sophisticated financial, claim processing, utilization review and quality assurance systems.

•Depending on specialty mix, can produce cost efficiencies, improved utilization profiles.

•Increased leverage in negotiations with hospitals and payers for capitation rates and inpatient risk pool.

CONS

•May not create same efficiencies of integrated group practice.

•Doesn't address expense side of physician practices.

•Often unwieldy, can be dominated by a few members.

Source: Health law specialist Peter Grant in a report for St. Paul Fire and Marine Insurance Company

Group Medical Practice

Provision of services by a groups of at least three physicians engaged in a formally organized, legally recognized entity.

PROS

•Economies of scale, lower practice costs.

•Centralized management, managed care expertise.

•Call coverage, regular hours, vacations.

•Attractive vehicle for recruitment.

•Marketplace leverage and access to managed care contracts.

•Collegial environment.

CONS

•Single site unattractive to geographically dispersed managed care payers.

•Traditional groups may have loose governance and compensation based on productivity.

•Poses difficulties for traditional groups in reorganizing to better deal with managed care issues, in empowering primary care MDs and in restructuring compensation systems.

Group Practice Without Walls

Physicians who unite to take advantage of operating efficiencies through shared expenses while maintaining independent practices. Can contract with HMOs.

PROS

•Achieve some benefits of fully integrated group practice without requiring MDs to move to single site.

•Relatively limited up front investment.

•Multiple geographic clinic sites may be more attractive to managed care payers.

•Potential to address expense side of practice.

•Vehicle for MD participation in true managed care risk contracting.

•Vehicle for sale of practice upon retirement.

CONS

•Limited economies of scale due to multiple locations.

•Non-integrated model lacks group discipline and culture.

•Diffuse governance and decision-making.

•May not be competitive with fully integrated groups.

•May attract MDs not interested in accommodating integrated group practice.

•Need to address incompatible MDs.

In the October *Iowa Medicine*, William DeMarco discusses capitation payment. Mr. DeMarco is a consultant who will speak at the IMS Oct. 27 conference "Organizing for Change".

FUTURES

Psychology of restructuring

NOTE: This article was written by Daniel Zismer, Ph.D., co-founder of Partners Consulting Group, Ltd. in Minneapolis, which specializes in physician-hospital ventures.

Reactions to forced integration

DENIAL
"We're doing fine."

RATIONALIZATION
"We're unique. This won't affect us for some time."

ANGER
"How dare they compromise my right to practice as I wish?"

GRIEVING
"What happened to the Golden Age of Medicine?"

DEFIANT RESOLVE
"I'll hang it up before I partner with the hospital medical staff."

DELUSIONAL PANIC
"We need to move now to safeguard our independence, autonomy and income."

QUALIFIED COMMITMENT
"We'll collaborate if we're in control."

RATIONAL RESOLVE
"Maybe neither of us are in control, so let's make the best of the collaborative potential while we can."

Market, payer and governmental pressures are forcing physicians and hospitals into a corner. Those who are organized within the traditional service delivery paradigm are, for the first time, facing system integration as their only viable response. Providers are moving up the integration ladder; physicians are forming groups, small groups are forming larger groups and larger groups are merging with hospitals and hospital systems.

When cornered, the response of physicians and hospitals is predictable and tends to progress through stages (see left margin). Moving from Qualified Commitment to Rational Resolve is the most difficult. When collaborative efforts collapse, they do so most typically under the weight of money and control. Upon closer examination, it's usually more the latter than the former since with control comes money, or so the logic goes.

Successful progress to the final stage requires 1) an honest appraisal of the environment, 2) a mutually developed vision, 3) a well-reasoned and affordable business plan and 4) leadership. The most critical of these requirements are vision and leadership. Physicians and hospitals "forced" to integrate frequently leap to structure prematurely. Early in the integration process, the would-be partners should devote sufficient effort to answering a fundamental question, "If we're successful, the cooperative venture will . . . "

As the market accelerates integration efforts, mutual security may supersede control as the primary driving force. Efforts by organized buyers, managed care plans and government are likely to encourage formation of some form of integrated service networks, also called accountable health plans. Recent trends portend the inevitability of redirected cash flow through systems which accept risk and align the financial and behavioral incentives of the provider system. Under one plausible scenario, physicians and hospitals will access patients and revenues as members of some duly organized and qualified integrated delivery system.

The psychology which accompanies the integration process is intriguing. Both parties negotiate within a somewhat defined and often confusing set of rules. Unlike negotiation in a "free market", health care integrations are governed by a litany of rules and laws; both state and federal. The most recent rules, made available by the Office of the Inspector General and Internal Revenue Service, provide guidelines for the financial portion of the transaction.

With financial parameters circumscribed, attention turns to aspects of control in the transaction; i.e., governance of the emerging system. Under a fully-integrated tax exempt structure, the preponderance of control must necessarily reside with a community board

and 501(c)(3) rules prohibit majority control by those deemed to be "insiders".

The composition of the traditional board may require restructuring as the community hospital transforms itself into an integrated health service system. Physicians will be added to the board to the extent that prevailing IRS code allows and any physician component of the integrated system may require a separate physician staffed oversight board and board committee structure to address such issues as clinical standards and protocols, credentialling and management of physician performance and compensation. As less than fully integrated systems emerge (PHOs, etc.), board composition is equally important, but somewhat less complex.

Beyond governance, the next major challenge is integrated health systems in division of revenues. Physicians' concerns for the hospital's control of medical practice is surpassed only by those related to the hospital's influence of personal income. The concerns are understandable. However, as hospitals and physicians integrate their businesses under risk sharing (capitated) payment plans, compensation methods must necessarily evolve as well. The traditional fee-for-service schemes become counterproductive in many instances.

In fully integrated models, physicians' compensation is more likely to evolve to base salary with incentive bonus opportunities governed by objective and subjective peer-based evaluations of productivity, quality, efficiency and overall value. Within integrated models, "hospitals" per se do not control physician compensation. Rather, methods of physician compensation are set by multidisciplinary senior management teams which include physician executives. Compensation must, of course, be market sensitive with incentives that favor overall system and managed care objectives.

Most rational people won't enter a deal until they fully understand the exit potential and consequence. Exit opportunities are typically designed somewhere toward the beginning of the transaction. Penalties for "unauthorized" exits are common and the price will vary according to the level of front-end investment. High investment, fully integrated systems, will carry higher penalties for exit. While most everyone recognizes the need to protect the new system, the design of exit options is delicate. The final design must be preceded by education and sufficient discussion of the risks, followed by a mutually agreeable, fair and equitable approach to the system and individuals who are the system.

Pursuit of the actual integration requires consideration of several factors within a complex mosaic — vision, strategy capital, management, technology, personnel and risk. Managing the psychology of the deal must be numbered among these. Failure to consider the psychological dynamics jeopardizes opportunities for success.

Several key questions frame the psychology of the deal (see right margin). Attention to these questions at the right times enhances the probability of success in the transaction and in operations of the integrated health care system.

Questions which frame the psychology of the deal

- *What's driving the change?*
- *What are the risks of the status quo?*
- *What are the benchmarks of a successful integration?*
- *How will the new entity be governed and controlled?*
- *How will finances be controlled?*
- *How will professional prerogatives be defined and preserved?*
- *How will the individual who perceives unfair treatment be heard?*
- *If it doesn't work, what are our options?*

Diabetes

"I thought if I felt O.K., I *was* O.K."

"Diabetes lies to you. You can feel good while it's quietly doing damage that may not show up until years later. I felt fine! And I figured if I took my insulin, watched my diet and didn't cheat too much, I'd be O.K.

"But it caught up with me, and the **Mercy Diabetes Treatment Center** had to get me back on my feet. Then they showed me — in a very practical way — what I needed to know to help keep me on my feet.

"Diabetes still tries to trick me into thinking I'm O.K., that I don't need to take care of myself. But now I can see through that lie, and I know what to do to live a good life."



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The Journal
of the Iowa Medical Society

Expanded maternal serum alpha fetoprotein screening

● ROGER WILLIAMSON, MD

Maternal serum screening for a variety of fetal conditions has reflected successful partnership among various groups, primarily the Birth Defects Institute of the State Health Department, members of the genetic divisions of obstetrics and pediatrics at University Hospitals, Iowa's practicing physicians and the University Hygienic Laboratory. As required by state regulations, all specimens for genetic and metabolic screening should be sent to this laboratory. This report updates the experience with maternal serum alpha fetoprotein (MSAFP) screening and describes results from a newer initiative to screen for Down syndrome (DS) and other chromosome abnormalities.

High resolution ultrasound

A pilot project begun in 1984 utilized MSAFP to screen for neural tube defects and other high risk pregnancies associated with placental dysfunction.[1] We initiated several changes which we believe can have a positive impact on the screening process. The first has been greater reliance on high resolution ultrasound to detect NTDs as opposed to amniocentesis in all cases wherein a woman has persistent elevations in MSAFP. The second modification has been a more aggressive approach to the pregnancy wherein the fetus is shown not to have a structural defect, but the pregnancy remains at risk for intrauterine growth retardation, third trimester bleeding, premature labor and fetal death.[2]

After an initial evaluation which may include an amniocentesis, we often recommend a second ultrasound at an appropriate interval to assess growth and other parameters. Based on this evaluation, the intensity of follow-up will be determined by the MSAFP levels, amniotic fluid volume, placental appearance by ultrasound and other tests of fetal well-being. It is probable that in certain cases, these recommendations will favorably influence pregnancy outcome.

Table 1 reveals the MSAFP screening experience in Iowa for the year ending 6/30/92. Of 13,525 women screened, we recommended tertiary level follow-up for 140. Slightly over one half selected amniocentesis; the remainder were reassured by an apparently normal

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for September 1994.

TABLE 1
MSAFP SCREENING 7/1/91—6/30/92

Recommended level II ultrasound and consideration for amniocentesis	140	*Abnormalities detected*	
		Neural tube defect	14 (includes 1 case each of encephalocele, iniencephaly and Meckel-Gruber)
Amniocentesis	76	Gastroschisis	2
Scan only	56	Epidermolysis Bullosa	2
Unknown	8	Oligohydramnios	4
		Congenital Nephrosis	1
		Sacrococcygeal teratoma	1
		Hydrops	2
		Triploidy	1
		Obstructed bladder	1
		47XXY	1

ROGER WILLIAMSON, MD
Contributing authors for this article include Joni Dotseth, RN; Jane Wilkins, RN; Jill Westercamp, M4; Glenda Mueller, RDMS and Stanley Grant, RN. The authors are associated with the U. of I. Hospitals and Clinics Department of Obstetrics and Gynecology.

Expanded maternal serum alpha fetoprotein screening

continued

ultrasound. Factors which influence performance of amniocentesis include maternal age 35 or greater, suboptimal views of the fetal spine and intracranial anatomy and any ultrasound abnormality including an altered amniotic fluid volume, growth retardation or a fetal structural defect. A normal ultrasound eliminates 95% or more of any MSAFP associated risk for a fetal NTD.[3]

A variety of fetal abnormalities emerge through MSAFP screening. Available data suggest when a woman has persistently elevated MSAFP values, fetal risk for a major birth defect is approximately 1 in 15.[4] About 1 in 5 women who had MSAFP levels which triggered follow-up services had a fetus with a defined abnormality, including 14 fetal NTDs. When a fetal NTD is detected, we attempt to provide prognostic information as accurately as can be obtained prenatally. For fetuses in the lower severity group (i.e., low lesions with no or minimal ventricular dilatation and no other apparent abnormalities), parents typically elect a continuation of pregnancy with planned delivery and early closure of the defect at a tertiary hospital in about one half of such cases. For all parents whose fetus has an isolated NTD, counseling includes the recommendation to consume 4 mg folic acid in the periconceptional period of any subsequent pregnancy. A well controlled study suggests the risk for recurrence (about 2% in the United States) can be decreased approximately 70% on this regimen.[5]

As MSAFP screening evolved it was noted that patients carrying fetuses with DS had lower levels of MSAFP. This decrease was sufficient to begin screening for this condition in women under age 35, using a calculation based on age and MSAFP level. Women under age 35 deliver approximately 80% of children with DS. About 25% of these cases can be detected in this age group with an amniocentesis rate of slightly less than 3% of screened women.[6]

We demonstrated similar sensitivity and specificity when screening for DS and certain other fetal chromosome abnormalities after this became a component of maternal serum screening in 1987.

Enhanced screening effectiveness

In 1988, a paper in the *British Medical Journal* demonstrated that screening effectiveness could be enhanced with the addition of two further maternal serum markers.[7] These were unconjugated maternal serum estriol ($MSuE_3$) and maternal serum human chorionic gonadotropin (MShCG). As with MSAFP, $MSuE_3$ is lower in pregnancies with DS fetuses, whereas MShCG is elevated.

TABLE 2
ESTIMATED EFFECTS OF SELECTING TWO COMMONLY USED CUTOFFS FOR SCREENING

Risk cutoff	False positive rate*	Detection rate†
1:190	4.5%	60%
1:270	8%	68%

Data adapted from Wald *et al, Br Med J* 1988;297:883
*False positive rate; proportion of unaffected pregnancies showing positive result
†Detection rate; proportion of affected pregnancies showing positive result

TABLE 3
RISK DISTRIBUTION BY VARIOUS COMBINATIONS OF MULTIPLE MARKER VALUES FOR A 35-YEAR-OLD WOMAN

	MoM*	MoM	MoM
MSAFP	0.4	2.5	1.0
$MSuE_3$	0.4	1.4	1.0
MShCG	2.0	0.5	1.0
Risk	1:16	1:52,000	1:1,400

Adapted from Wald *et al, Br Med J* 1988; 297:883
*MoM; multiples of the normal median (obtained by dividing an individual's value by the median for the relevant gestational week)

It was anticipated that by applying triple marker screening across the entire pregnant population, 60% of DS fetuses could be detected with an amniocentesis rate of about 4.5%. This information was reviewed in *Iowa Medicine* several months prior to initiating screening based on maternal age and the three serum assays in the summer of 1990.[8]

One issue when beginning to screen is to decide the risk cutoff one chooses to suggest amniocentesis. Some programs have selected a cutoff of 1 in 270, whereas others, including ours, have selected a cutoff of 1 in 190. As Table 2 demonstrates, a cutoff of 1 in 270 confers a large increase in the false positive (amniocentesis) rate with little gain in detection rate.

Another feature of using more markers is

that the risk distribution can be considerably expanded for an individual, with obvious counseling implications (Table 3). For instance, a 35-year-old woman at midgestation has a risk of having a fetus with Down syndrome of approximately 1 in 270 before screening. If this woman has the values shown on the left, a lower level of MSAFP and $MSuE_3$ and an elevated MShCG of 2.0 MoM or multiples of the median, the risk is computed to be 1 in 16. However, if she shows the pattern in the middle column with an elevated MSAFP, a modest increase in $MSuE_3$, and a reduction in MShCG to 0.5 MoM, the computed risk is considerably reduced at 1 in 52,000. A woman with median values for all three levels is also given a reduction in risk, about 1 in 1,400.

Multiple marker protocol study

The largest prospective study evaluating the multiple marker protocol was recently published in the *New England Journal of Medicine*.[9] For this study, an amniocentesis was suggested for a calculated risk of 1 in 190 or greater. Twenty-five thousand women were screened, and after a local dating ultrasound for women called "positive" and recalculation of risk if necessary, 3.8% of screened women were candidates for an amniocentesis.

Of women accepting amniocentesis, DS was detected in 1 in 40 procedures and all chromosome abnormalities in 1 in 24 procedures. This prospective data has demonstrated a higher detection rate and lower false positive rate than predicted.[7] The detection of DS in 1 in 40 procedures compared favorably with a detection rate of 1 in 140 procedures when using maternal age 35 and above as a criterion for amniocentesis. A detection rate of about 1 in 90 per procedure was seen when screening for Down syndrome with MSAFP alone in women less than age 35.[6]

We have been utilizing a DS screening protocol similar to that published.[9] To validate the screening process, we attempted to ascertain cases of liveborn DS infants in the state for calendar year 1991, those whose mothers could have availed themselves of testing during the first year of triple hormone screening. We were able to account for approximately three-fourths of the expected number of infants with this condition by requesting data from the Cytogenetic Laboratories at Mayo Clinic, the University of Nebraska at Omaha, and the laboratory at University Hospitals in Iowa City.

TABLE 4
TRIPLE MARKER SCREENING IN IOWA
7/1/91—6/30/92

13,525 women screened		
↓		
528		
amnios recommended		
3.9%		
↓		
412		
women accepted		
78%		
↓		
8 cases DS	→	1 case/52 procedures
↓		
1 case trisomy 18	→	All chromosome abnormalities
1 case trisomy 13		in 1/41 procedures

Additionally, 1 further case of trisomy 18 was detected by a lower level of all 3 markers

Four infants with Down syndrome were determined to have been born of mothers called screen negative (risk < 1 in 190). Only 1 of these 4 infants would have been detected had the cutoff been set at 1 in 270 versus 1 in 190. For 1991, approximately 70% of DS cases we ascertained as described above were detected in the women who underwent screening.

Table 4 provides more detail concerning the false positive rate and detection rate for this screening in Iowa for the year ending 6/30/92. Of 13,525 women screened, an amniocentesis was recommended for 3.9%. Of those accepting the procedure (78%), 8 cases of Down syndrome were detected, a detection rate of 1 in 52 procedures. Additionally, 1 case of trisomy 18 and 1 case of trisomy 13 were detected. As shown, the false positive rate is slightly lower than projected and the detection rate is in line with predictions.

Effective screen for trisomy 18

The maternal serum hormone profile for fetuses with trisomy 18 is unique. MSAFP and $MSuE_3$ are decreased, as with DS, but MShCG is also quite low. If all three assays are decreased below a defined cutoff (MSAFP $\leq$ 0.75 MoM, $MSuE_3 \leq$ 0.60 MoM, MShCG $\leq$ 0.55 MoM), an amniocentesis is suggested.

Expanded maternal serum alpha fetoprotein screening

continued

It has been prospectively demonstrated, including a study which our center has participated in, that the increase in amniocentesis rate will be about 0.4% if this protocol is followed.[10] Also, about 1 in 16 procedures will be associated with trisomy 18, making this a very effective screen for this severe disorder.

These pregnancy screening protocols are complex and we have found it benefits participants when the program is a part of a centralized, efficient and comprehensive service. The laboratory component is critical. Participation in an external quality assurance program helps ensure accuracy and precision and prevent drift of the assay medians over time.

Lastly, because there is no specific therapy for these disorders which are detected and for many other reasons, screening should be voluntary with freely given informed consent.

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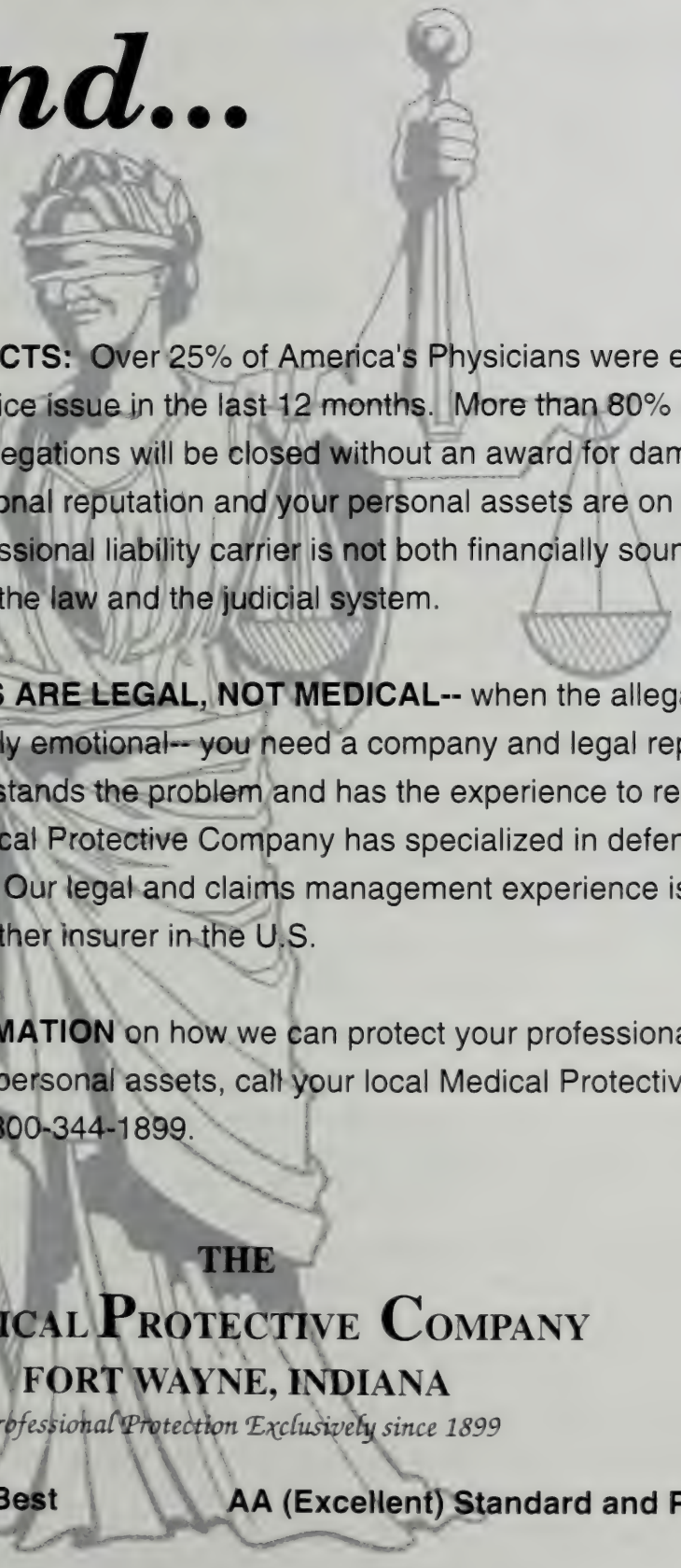
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On journalism and babbling

Though a medical journal constitutes a journalistic effort, it fortunately does not present news in the manner as lay media. News constitutes a report of recent events, recent meaning "of or relating to a time not long past".

Journalism is defined by Webster as "writing characterized by a direct presentation of facts or descriptions of events *without an attempt at interpretation*". If we hold to the last part of this definition how can various media call themselves journalists?

Of course, we are aware of the way the media present news. It would seem those who call themselves journalists are in reality trying to out-do each other for selfish ends . . . ratings. They present data of marginal merit with a lot of interpretation either of their own concoction or dictated by their editors or advisors.

Events of recent weeks and months, whether related to sports or entertainment personalities, members of governmental bodies or private citizens, emphasize my questioning of today's journalism. Polls have shown a large proportion of the public would welcome restraints upon the presentations of news.

Of course there are those who delight in details, while others resent the television media usurping regularly scheduled programs to reiterate hour after hour happenings that could be summarized in a few minutes. Newscasters "report," "analyze" and "interpret" certain happenings to such an extent that their meaningless mouthings border on babbling.

I will not enter into debate regarding our Constitutional right to freedom of speech and all the ramifications thereof. There is no doubt that such freedom is inherent in our society, but is it too much to expect that in many instances "enough is enough"?

For example, civil and criminal trials should be within the domain of the courts and the media should report only final results.

Now back to medical journals. No glaring headlines, no wild pronouncement shall invade *Iowa Medicine*. Scientific articles will be presented succinctly by the authors. The reader may draw individual conclusions on the data presented and should feel free to respond if so desired via a letter to the editor. Society news will be presented in a factual manner with interpretation at the discretion of the reader. When controversy is imminent, the pros and cons will be presented.

Is it too much to expect that in many instances "enough is enough"?

Now, isn't that refreshing in contrast to the presentation of news in the "journalism" style of radio, television, newspapers and news magazines? IM



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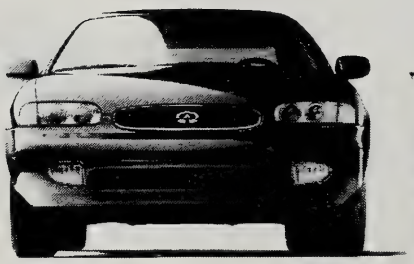
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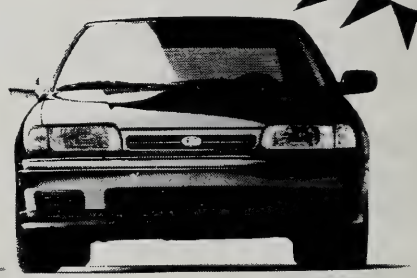


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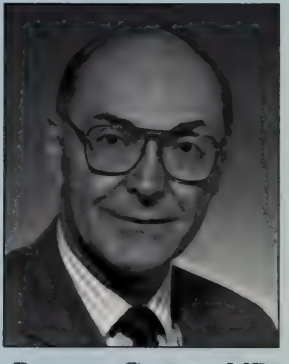
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Muses and museums



Richard Caplan, MD

My recent trip to England included a stunning series of museum visits. Some related to the life and activities of Sir William Osler, the medical giant at the turn of this century, in whom I have a special interest; others related generically to medical history and practice. For example, the Hunterian Museum at the Royal College of Surgeons, and its superb ancillary museum for anatomy instruction, inspire any thoughtful physician.

The museum and library of the Wellcome Institute for the History of Medicine also deserve considerable time. The British Museum, full of wonders, cannot be outdone even by our own Smithsonian family of museums in Washington. (Announcement has just been made that a new Smithsonian Museum of Health and Medicine will soon be built on the mall in Washington, D.C. Count on its being superb.)

A host of public and private museums call the visitor; museums of science, of religions, of fine arts of all varieties, of Sherlock Holmes, etc. Perhaps the smallest museum I've ever encountered, yet of consuming interest, was the cramped laboratory of Sir Alexander Fleming at St. Mary's Hospital, where in 1928 he found the fateful Petri dish of *Staphylococci* contaminated with a growth of *Penicillium*. Others had surely found similarly "ruined" cultures, but failed to observe and interpret correctly what lay before them.

My visit reminded me that a museum is a place inhabited by the muse(s), that is, a place where objects and ideas are displayed, where imagination and creativity can edify and entertain us. Therefore, a museum need not be confined within a building. I repeatedly had the sense that I was walking around in a museum, even if called "Selfridge's Department Store" or the "Royal Gardens in Regent's Park," or when it was the panorama of clothing or hairstyles seen on the streets, or the theatres and restaurants near Leicester Square, or the majestic rows of elegant Georgian homes on Harley St. where specialists still see their patients. And beyond the confines of metropolitan London lie living museums, like the thatched-roof Tudor homes of many towns, the green fields where the Battle of Hastings in 1066 radically altered our own language and culture, the countryside divided into tidy plots of land bordered by foliated hedges, the roadside flowers and neat plantings around most dwellings.

A museum need not be confined within a building.

The D-Day Museum at Portsmouth is another "must visit". Its fabulous 34 huge panels of embroidered illustration included the importance of medical services in that invasion, specifically acclaiming blood transfusions (an effort under the command of Dr. Robert Hardin, subsequently dean of the University of Iowa College of Medicine).

All this consciousness of museums has sensitized me to my everyday world. The muses live everywhere. You could start noticing them, too; for example, each patient—body, mind and pathology—is yet another museum. IM

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Advertising Rates and Data

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FRONT ROW: Ruth Clare, Bernie Lowe, Mary Sievers
BACK ROW: Terri DeGroot, Don Neumann, Patty DeFrancisco

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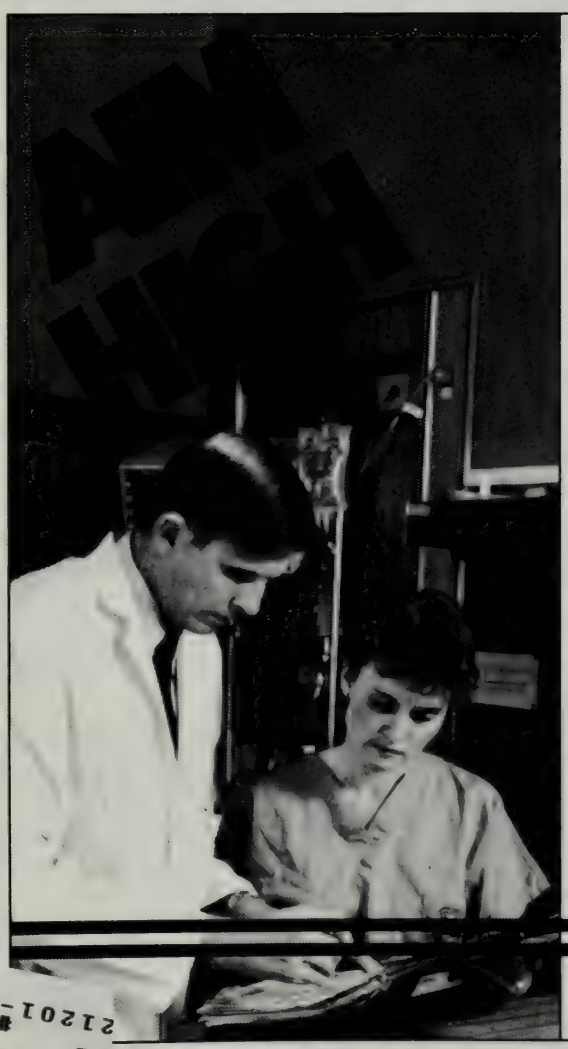
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1701 22nd Street, Suite 201
West Des Moines 50265
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
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Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
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Fort Dodge 50501
515/573-4141

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Waterloo 50702
319/234-6446
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Certified by American Board of Electrodiagnostic Medicine

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Ankeny 50021
515/964-2772 or 1-800/729-7813
Locum Tenens
Doctor on Call

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Chest, Infectious Diseases & Critical Care Associates, PC
Daniel H. Gervich, MD
Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

Infertility

Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
Reproductive Endocrinology/Infertility
IVF and GIFT Procedures
Donor Oocyte Program
Artificial Inseminations
Reproductive Surgery
Menopause Management

Internal Medicine

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Cardiology
Samir G. Artoul, MD, FICC
Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurology

Iowa Medical Clinic Neurology
Andrew C. Peterson, MD
Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
Neurology, EEG, EMG, Evoked Potentials and Sleep Studies

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurosurgery

Iowa Medical Clinic
Neurosurgery
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
1215 Pleasant, Suite 608
Des Moines 50309
515/283-5760
Neurological Surgery

Des Moines Neurosurgeons, PC
Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
2600 Grand Avenue, Suite 210
Des Moines 50312; 515/283-2217

Chad D. Abernathey, MD
1953 1st Avenue SE
Cedar Rapids 52402
319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
Earl R. Elowsky, MD
Timothy W. Neff, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Ophthalmology

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
540 E. Jefferson, Suite 201
Iowa City 52245
319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Timothy F. Moran, Jr., MD
2800 Pierce, Suite 106
Sioux City 51104
712/252-4333
General Ophthalmology

Fox Eye Institute
Lee Birchansky, MD
Mario Mota, MD
510 10th Street, SE, Cedar Rapids 52403
1400 7th Avenue, Marion 52302
1-800/I SEE YOU

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Norman F. Woodlief, MD
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Todd W. Gothard, MD
309 East Church
Marshalltown 50158
515/754-6200

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West Des Moines 50266
515/223-8685

804 South Kenyon Road, Suite 100
Fort Dodge 50501
515/576-7777

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

Orthopaedic Surgery

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Kirk D. Green, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Otolaryngology

Phillip A. Linquist, DO, PC
1000 Illinois
Des Moines 50314
515/244-5225
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

Iowa ENT, PC
Thomas A. Ericson, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
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Des Moines 50309
515/241-5780

1200 35th Street, Suite 200
West Des Moines 50266
515/225-7761
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Daniel J. Blum, MD
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Marshalltown 50158
515/752-1566

Lakeview Medical Park
6000 University Avenue, Suite 310
West Des Moines 50266
515/224-9533

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319/277-3105
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(Continued next page)

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Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

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Eugene Peterson, MD
Richard B. Merrick, MD
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Des Moines 50312
515/274-9135

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James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
310 North Grandview Avenue
Dubuque 52001
319/588-0506

Pain Management

Mercy Center for Pain Management
Randall L. Busch, MD, MS, DDS, Director
1890 John F. Kennedy Road
Dubuque 52002
319/556-7542
fax 319/556-8334

Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
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Cedar Rapids 52401
319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

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Davenport 52804-1769
319/383-1466
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Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

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Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Younkers Rehabilitation Center
Iowa Methodist Medical Center
1200 Pleasant
Des Moines 50308
515/283-6434

Pulmonary Medicine

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Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Ronald L. Rains, MD
Pulmonary Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hour 515/224-1777

Fort Dodge Medical Center, PC
Robert C. Ang, MD, FCCP
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Surgery

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Des Moines 50309
515/241-5767
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Dan P. Warlick, MD, FACS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Urology

Fort Dodge Medical Center, PC
Leland M. Coffman, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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The importance of choice

Imagine these two scenarios: Your insurance doesn't cover your illness if you allow a certain doctor to treat you or if you travel to a clinic out of town. A call to the doctor gets a nurse, a physician's assistant or a clerk who feels you should wait awhile and your plan won't cover a visit to another physician.

Choice in health care is something Americans take for granted. However, we may soon have a different experience. If patients pay in advance for care in the form of premiums, why should our choice be denied?

Any sponsor of a health care benefit plan that limits access to providers should have a "point of service" option which allows enrollees access to physicians outside the plan or network.

Patients should have a range of health plans such as HMO, PPO and traditional insurance plan. The problem is not managed care, but managed care profiteering which can divert exorbitant profits from health care.

Giving patients choices is the best antidote to this profiteering. In the era of managed care, problems occur which we didn't have under the fee-for-service practice.

In fee-for-service, the concern was overtreatment for the purpose of generating a fee. In managed care, the patient should know when they enroll who authorizes or reviews the care, what financial arrangements or other incentives exist to withhold services and what impact any limitations have upon the patient. In a managed care setting, the more economically productive provider is more desirable than a less productive provider.

In the past, a physician working for and by himself or herself could practice at any pace he or she desired. Credentialing of physicians in a plan should be based on standards of quality and physicians must be allowed to provide input into policies. Managed care plans must be prohibited from terminating a physician without cause.

Physicians must have due process for protection of patients and standards for the certification of qualified utilization review programs. Standards need to be based on sound scientific principles developed with physician input. The review programs should be released to the physicians and the public.

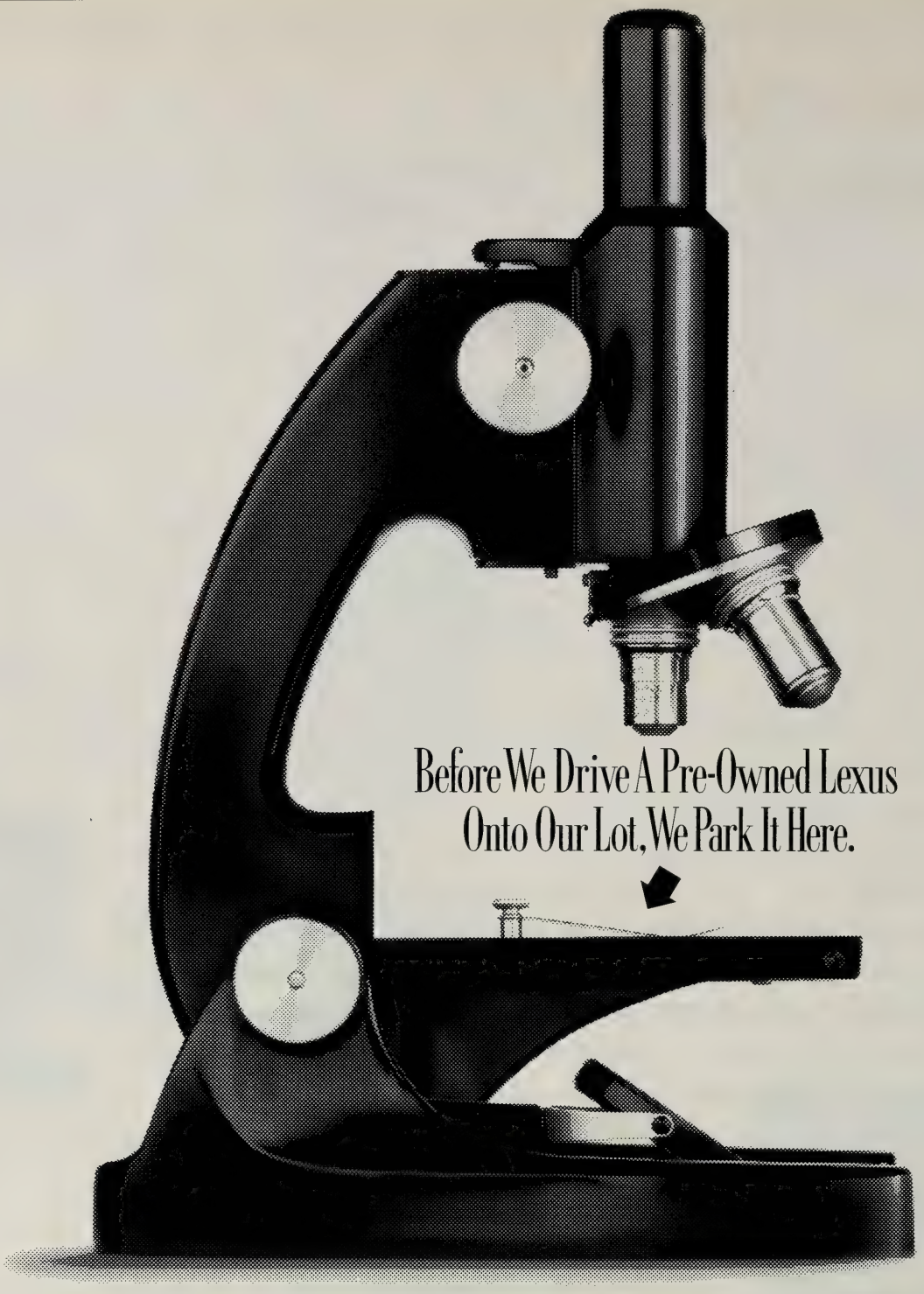
The AMA's Patient Protection Act contains safeguards needed by patients.

As the system changes from fee-for-service to managed care, a new set of problems arise and must be dealt with.

The AMA's Patient Protection Act (PPA) contains safeguards needed by patients and physicians in this new environment. The PPA would ensure that patients and their physicians control care choices, not insurance companies. It would ensure that patients have information about what their plan covers. Please tell your legislators in Washington that the Patient Protection Act needs to be part of any health system reform. IM



James White, MD



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Zero tolerance for violence

The mission: to unite central Iowa's citizens in a common awareness of violence in order to implement ongoing strategies that reflect zero tolerance for violence.

This statement has guided IMSA in coalition efforts to reduce the incidence of violence in our communities. National statistics that caused us to mobilize our energies in this direction are quite alarming.

Under the direction of Jan Bannister, health promotion committee chair on community violence, the IMSA entered into a coalition with Polk County local governments, law enforcement and judicial entities, educational institutions, health and human service organizations, business and media organizations.

The coalition met weekly and the strategy selected was to host 17 town meetings, sponsor a Symposium on Violence (May 26, 1994, at the Des Moines Convention Center) and facilitate follow-up groups to identify and implement violence prevention strategies.

It was our privilege to be a major contributor to this coalition by offering the AMA/AMAA video "Violence in America" as the opening event at the symposium and all 17 town meetings. This video solicited viewers to "join with America's physicians" in the fight against violence.

The day-long symposium brought together nearly 700 people to hear keynote speakers from Pepperdine University; Dr. Ronald Stephens, national authority on violence and strategies for violence prevention, and Dr. Bernard James, expert in Constitutional Law and its relationship to violence prevention.

In the afternoon, participants chose from 17 workshops on specific violence prevention strategies. These included making neighborhoods safer, hate crimes and prejudice, gangs, domestic violence, satanic cults, parenting, street crime, civil rights and constitutional law, workplace violence and antisocial children.

After the symposium, focus groups attended a follow-up town meeting (June 2, 1994, at the Botanical Center in Des Moines,) to begin the ongoing process of implementing strategies that will result in a "zero tolerance for violence" throughout the community. Participants organized into subcommittees including Youth Empowerment, Parent Commitment, Community Assessment, Neighborhood Involvement, Individual Volunteer Efforts, Cultural Awareness and Legislative Action.

National statistics that caused us to mobilize our energies are quite alarming.

The "how-tos" of organizing this type of coalition are being packaged by the Alliance to be offered to all organized counties in the state for implementation at the local level.

We look forward to combining forces with the IMS anti-violence programs and welcome the opportunity to become part of the IMS Task Force on Domestic Violence.

There is much work to be done in maintaining a zero tolerance for violence in Iowa, but the good news is: working together, we can accomplish a great deal! IM



Barbara Bell
President
IMS Alliance



IMS Update

Do you have a plan for the future of your practice? Attend the Iowa Medical Society's statewide *Futures* conference "Organizing for Change" October 27 in Des Moines. Look on page 439 for further details and a registration form.

AT A GLANCE

The first meeting of a new advisory committee involving the IMS executive vice president and selected clinic managers was held last month. The committee will meet periodically to discuss issues of mutual concern to clinic managers and organized medicine.

Due to the Revenue Reconciliation Act of 1993, a portion of association dues attributable to certain political activities is not deductible as a business expense. This means 19% of 1995 IMS dues and 33% of 1995 AMA dues are not deductible as a business expense for federal income tax purposes. No portion may be deducted as a charitable contribution. Also, no portion of dues to IMPAC or AMPAC may be deducted as a charitable contribution.

IMS task force seeks physician experts

The Iowa Medical Society's Task Force on Domestic Violence is seeking physician experts in various aspects of partner abuse. If you know of any Iowa physician who has expertise in any aspect of partner abuse (clinical, psychological, legal documentation, using local resources), please call Chris Clark at IMS headquarters, 515/223-1401 or 800/747-3070. October is Domestic Violence Awareness Month. According to an editorial by Dr. Robert McAfee, AMA president, physicians have "a responsibility to help stem this growing American epidemic."

The IMS Task Force on Domestic Violence is undertaking a comprehensive effort to educate physicians on how to help victims of domestic violence. Watch for more information on this important IMS priority.

Directory mailed; dues statements coming

The 1994-95 IMS Membership Directory is scheduled to be mailed this week to all IMS members. The directory contains a listing of all IMS members and other information regarding individual physician practices, county medical societies and specialty societies. On the back of the directory is a list of which IMS staff member to call for information on a particular subject.

IMS 1995 dues statements are also scheduled to be mailed soon, with a message from James White, MD, IMS president. Prompt payment of your dues will be appreciated. Look on page 451 of this *Iowa Medicine* for an article on benefits of IMS membership.

Don't miss the Deadline News page

Iowa Medicine now has a special **Deadline** News page which will appear each month directly inside the front cover. This page covers health care news which occurs after the usual monthly magazine deadline. Due to time constraints, an abbreviated format is used. Don't miss this new addition to your magazine.

Iowa Medicine survey results

Thank you to the over 1,300 Iowa physicians who answered our survey on readership of the new *Iowa Medicine*. The results have been studied by the IMS Board of Trustees and will be used by a committee appointed to analyze IMS communications.

According to the survey, 63% of IMS members read at least portions of the magazine every month. Socioeconomic and scientific material is read by an equal number of physicians. The magazine's new format, initiated last January, drew many favorable comments.

Specialty Society Update

The new IMS Executive Vice President IMGMA Advisory Committee met for the first time September 12. The committee will advise Eldon Huston, IMS executive vice president. Members include IMGMA officers and other senior administrative staff of Iowa clinics. The group discussed the IMS *Futures* program and reviewed 1994-95 IMS priorities. The group will meet in January to discuss legislative issues.

The IMGMA Annual Meeting will be October 13-14 at the University Park Holiday Inn, West Des Moines.

IMGMA will offer a second "Management Education Program" (MEP) in March. The first program has been highly praised by the 12 physicians and 18 clinic administrators enrolled.

The Iowa Psychiatric Society Annual Meeting will be October 14 in Iowa City.

Health System Reform

AMA offers POWER hotline

The AMA has created a toll-free hotline offering physicians late-breaking updates on the status of health system reform in Congress. The hotline is 800/833-6354. The service is part of the POWER (Physicians Organized to Work for Effective Reform) network. Callers will hear a message describing floor activity and its impact on medicine.

Media analyst compliments AMA

In a recent presentation to Midwest legislators gathered in Des Moines, media analyst Kathleen Hall Jamieson complimented the AMA on its "positive ads" so far during the health system reform debate. The AMA has done a good job of presenting reform measures it favors rather than simply criticizing other plans, she said.

She said one problem with media coverage of health system reform is that there is a crisis in "cost and coverage, not a crisis in health care."

Reform tide becomes a trickle

Congress will likely have only 4-6 weeks remaining after the Labor Day recess before adjourning, a very short period to pass health system reform bills in the House and Senate. There appears to be no consensus for any approach to comprehensive reform and congressmen will be anxious to head back home to campaign.

House and Senate leadership have begun to discuss working on a more modest bill, or perhaps waiting until the next congressional session to deal with the issue.

Public opinion polls show Americans are not as concerned about health care as they are about other issues and would rather Congress do nothing than pass a bad bill.

The *New York Times* devoted a front page story and two full pages to the chronology of events surrounding the President's reform efforts entitled "What Went Wrong —How the Health Care Campaign Collapsed".

Meanwhile, the *Wall Street Journal* began predicting what physicians have known for months — that health system reform will be forged in a marketplace tussle between cost-minded purchasers and rapidly merging providers. The Associated Press and other media also began reporting on market forces which have been in motion for some time and have gathered momentum, regardless of the lack of action in Congress.

IMS *Futures* program continues

During the last part of September, five regional meetings were held around Iowa as part of the Iowa Medical Society's ***Futures*** program. At these meetings, physicians discussed local managed care developments.

On October 27, a special IMS one-day conference entitled "Organizing for Change" will be held at the Marriott Hotel in Des Moines. The conference is open to any Iowa physician. See page 439 of this issue for more information and a registration form.

This *Iowa Medicine* contains two feature articles on managed care issues. They are written by experts who will speak at the October 27 conference.

Worth Repeating

"There is significant bipartisan support in Congress and the general public for effective medical liability reform to improve access, contain costs and ensure adequate compensation for patients who are wrongfully injured. All that stands in the way is a group of lawyers intent on keeping their personal gravy train rolling along."

George McGovern, former US Senator, in a *Wall Street Journal* editorial entitled "Sneak Attack on Malpractice Reform".

AT A GLANCE

Don't miss the special insert in this month's Iowa Medicine *describing the Health Employer Data Information Set (HEDIS) and other health data collection efforts underway in Iowa and nationwide. This is the first in a series of three inserts.*

The Health Care Liability Alliance is applauding a group of Senators who have criticized the Clinton-Mitchell reform plan as turning back the clock on malpractice reform. The bill actually preempts state tort reform laws.

AMA is urging state medical societies not to support the Harkin/Hatch amendment on "out of network" providers until they see specific language.

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Legislative Affairs

LEGISLATIVE VIDEOTAPE AVAILABLE

A videotape presentation is available to Iowa physicians who want information on the Iowa Medical Society's priorities for the 1995 session of the Iowa Legislature. The tape is about 20 minutes long. Dr. Kevin Cunningham, chairman of the IMS Committee on Legislation, reviews legislative priorities; Dr. William Eversmann, Jr., a member of the Governor's Health Reform Transition Team, discusses health system reform.

There is also a discussion of the importance of grass roots involvement in the political process. As scheduling permits, Paul Bishop, IMS legislative liaison, will be on hand to answer questions after the tape is shown. The videotape would make a good short program for county medical societies or specialty society meetings.

To arrange for a legislative briefing in your area, call Becky Roorda or Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

1995 IMS legislative priorities approved

Health system reform and CHMIS will be among top IMS priorities when the Iowa Legislature convenes in mid-January. The priorities were chosen by the IMS Committee on Legislation, chaired by Dr. Kevin Cunningham, and approved by the IMS Board of Trustees at its September 22 meeting.

Priorities approved by the IMS Board include:

Iowa Health Reform Transition Team

The Iowa Health Reform Transition Team is the successor to the Governor's Health Reform Council. The team may develop recommendations as it meets throughout the fall. Because federal legislation has not been passed, reform may again be up to individual states in 1995. The IMS is a participant in transition team activities.

Patient Protection Act

The American Medical Association has developed state model legislation similar to its Patient Protection Act, which AMA is advocating at the federal level. This legislation was designed to assist state medical societies in addressing similar issues on the state level, though it is up to the individual states to decide the best strategy given circumstances. The legislation provides a basis for working with other groups on reform issues.

Managed care

The IMS supports the right of all physicians to apply to any managed care entity and be judged for admission based on physician-developed objective criteria, primarily professional competence and quality of care. Managed care organizations should be required to disclose criteria used to select, retain or exclude a physician, including criteria used to determine geographic distribution and number of specialists needed.

Coverage for serious mental illness

IMS opposes discriminatory benefit limitations, copayments or deductibles for treatment of psychiatric illness under existing health care plans and opposes discrimination in any proposed plans for national health care coverage or universal access for the uninsured.

Liability reform

Liability reform continues to be a top IMS priority. Efforts to reform the health care delivery system and contain costs will not work without meaningful liability reform.

Universal helmet law

The federal government requires states to enact comprehensive helmet use legislation for motorcyclists or face diversion of a portion of federal highway construction funds. Legislation to attempt to replace the diverted funds with a higher fee for nonhelmeted motorcyclists was passed in 1993 and vetoed by the Governor. IMS is working with the

continued

AT A GLANCE

According to a recent editorial in the Wall Street Journal, *it's hard to overestimate the public's dissatisfaction with the federal government. A new Associated Press poll found that only 14% of the public trusts Congress to do what is right.*

According to the Iowa Department of Public Health (IDPH) the Volunteer Physician Program is up and running. The program offers protection from lawsuits to Iowa physicians who volunteer their services. Any physician licensed by the BME to practice in Iowa is eligible and the application process is simple. For more information, call Kevin Teale at the IDPH, 515/281-6692.

Legislative Affairs

continued

Helmet Law Coalition in support of legislation requiring approved headgear for motorcyclists and passengers.

Tobacco free environment

The IMS has worked with the Tobacco Free Coalition for several years. Likely components of legislation include improving tobacco law enforcement by designating the Iowa Department of Public Health as the lead enforcement agency, prohibiting smoking in hallways, all work sites and day care centers and requiring more separation of smoking and nonsmoking areas in restaurants.

Other issues include review of HIV/AIDS laws and modification of Iowa's Anatomical Gift Act.

Watch the November *Iowa Medicine* for more information on IMS priorities, including scope of practice and self-referral issues.

Physician's wife breaks political barrier

Kim Landhuis of Fort Dodge is breaking new political ground in her bid for the Iowa Senate seat held by Republican Jim Kersten. Kersten is not seeking reelection.

According to a recent story in the *Des Moines Register*, Landhuis, married to Fort Dodge family physician Jesse Landhuis, is the first Southeast Asian immigrant to run for the Iowa Legislature.

Landhuis has lived in Iowa for 21 years and is former school board vice president. She is running against Rod Halvorson, a Fort Dodge Democrat. Of 150 Iowa legislators, 22 are white females and one is a black male.

Richard Schwarm, chairman of the Iowa Republican Party, calls Landhuis "an articulate spokesperson for Republican ideals."

Her positions include: opposition to legalized abortion except to save the mother's life; opposition to legislative mandates for local governments without providing funding; support for local property tax limits; cutting school-related bureaucratic waste.

She also favors a shift in education policy to go beyond the basics to "21st century education" including creative problem-solving.

Landhuis wants to make parents — both rich and poor — more accountable in order to solve problems such as unwed teen pregnancy. One suggested measure is required parenting classes for welfare mothers.

Landhuis said the state must also stop practicing deficit spending. IM

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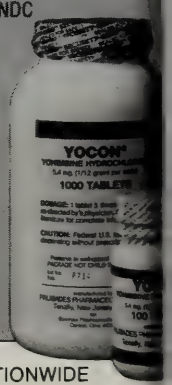
Dosage and Administration: Experimental dosage reported in treatme erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males orally. Occasional side effects reported with this dosage are nausea, dizzi or nervousness. In the event of side effects dosage to be reduced to ½ ta times a day, followed by gradual increases to 1 tablet 3 times a day. Repo therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Medical Economics

Do you have questions on OBRA '93 Stark II physician referral legislation?

The prohibition against physician self-referral, previously applicable only to clinical laboratory services, will be extended to additional services after December 31, 1994. These services include: physical therapy, furnishing of durable medical equipment, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, prosthetic devices, home health services, outpatient prescription drugs and inpatient and outpatient hospital services.

IMS has a summary of the Stark II provisions on self-referral from OBRA '93. To get a copy, call Donna Bottorff or Linda Tideback at IMS, 515/223-1401 or 800/747-3070.

Vaccines For Children program in trouble

According to a recent issue of *JAMA,* the Vaccines For Children (VFC) program — the president's much touted plan for immunizing more than 90% of the nation's children — is in trouble. The General Accounting Office issued a strongly critical account of the program and two congressional hearings have aired further criticism. The program was to begin October 1 but has now been indefinitely delayed until problems identified by the GAO can be rectified.

The VFC program is intended to provide vaccines for children who would not otherwise receive them, including Medicaid enrollees, those without health insurance, those who are underinsured and those covered under the Indian Health Services Act.

However, as the GAO report notes, free vaccines are already available to these groups.

HCFA initiates pilot sanction program

The Health Care Financing Administration is initiating the third phase of its Comprehensive Limiting Charge Compliance Program (CLCCP), a sanction pilot program.

CLCCP was introduced by HCFA in 1992 to monitor limiting charge compliance and provide corrective action. In October of that year, HCFA introduced the Limiting Charge Exception Report which required physicians to refund the overcharge to Medicare beneficiaries and document the refund.

Phase II was initiated in March of 1994 and involved notices sent to physicians violating the Limiting Charge for the same CPT code more than five times, or had a total violation of over $500. There were 36 notices sent to physicians or clinics during the first reporting period.

Phase III — the pilot sanction program — will focus on physicians or clinics who commit violations over a substantial period of time, with large overcharges and with substantial numbers of violations. HCFA has instructed each carrier to submit five cases meeting these criteria. HCFA will then identify those physicians for the sanction pilot.

It is possible no Iowa physicians will be selected for the sanction pilot but it is important for every physician to make every effort to comply with CLCCP since HCFA is moving forward with the program.

IMS HEDIS Committee activities

A special Iowa Medical Society committee has been charged with studying the Health Plan Employer Data Information Set (HEDIS). HEDIS is a national employer initiative to develop a set of standards for reporting and assessing the performance of a

continued

AT A GLANCE

A Missouri cytology lab used by eight state agencies in Iowa has been closed by CLIA. The lab was reportedly reading more than the allowable number of slides per day. Iowa physicians should be aware that pap smears for some patients may have to be redone. For more information, call Donna Bottorff of the IMS staff, 515/223-1401 or 800/747-3070.

The AMA, in a letter to all members of the Senate, has endorsed an amendment that would eliminate work force allocation requirements from any health system reform legislation. The letter said the AMA recognizes the need to train more primary care physicians but said "rigid quotas such as those found in the Mitchell bill" are not the best approach.

Medical Economics

continued

health plan. The committee's goal is to understand and have input into the document designed to address major areas of a medical plan's performance. These areas include quality, patient access, patient satisfaction, membership and utilization, finance and descriptive information on health plan management and activities.

The IMS HEDIS Committee met August 29 for an all-day retreat. Several people affiliated with the national HEDIS 2.0 initiative provided an overview of the system and its potential impact on physicians.

The committee will be making a recommendation to the IMS Board of Trustees regarding future educational efforts. IM

Iowa physicians and data collection:
IS YOUR OFFICE READY?

Developments in the area of health data collection cannot be ignored by physicians. Health data is already being used to make key decisions about health plans and it is vital for physicians to help find useful ways to collect and analyze health care delivery data.

This issue of *Iowa Medicine* contains the first of three special inserts on why physicians must become knowledgeable and involved in data collection systems such as the Health Employer Data Information Set (HEDIS).

This month's insert provides background information on the forces behind health care data collection. The November insert will compare HEDIS, the Community Health Management Information System (CHMIS) and other important data collection efforts. The December insert will discuss ways every Iowa physician can participate and become a leader in this field.

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Practice Management

Medicare cardiac catheterization payment

HCFA has revised its computation and the payment for cardiac catheterizations. The result is a big win for Iowa cardiologists.

In 1994, cardiac catheterization CPT codes were revised to reflect current medical practice. Because the codes were new, there was no payment history available for changing the payments to the RBRVS system. This caused the new codes to go straight to the Medicare fee schedule with no transition period.

Since the new 1994 catheterization codes were not subject to transition, physicians experienced the full fee schedule decrease in one year. This table represents estimated increases for catheterization's professional component:

LOCALITY	% INCREASE
1. Southeast Iowa	33%
2. Northeast Iowa	38%
3. North Central Iowa	39%
4. South Central Iowa	36%
5. Polk/Warren	33%
6. Northwest Iowa	34%
7. Southwest Iowa	36%

The October *MEDICARE INFO* contains the new Medicare fee schedule. The amounts are retroactive to services on and after January 1, 1994 but the carrier will only reprocess claims which are brought to their attention. Involved claims can be submitted for review at the same time. Send claims to Medicare Station 209.

E & M coding workshops announced, HCFA documentation guidelines included

In November, the IMS will present five workshops across Iowa on CPT Evaluation and Management (E & M) coding. The workshops are designed for physicians and will include Iowa utilization data by specialty compared to the U.S.

The HCFA documentation guidelines for E & M codes will also be provided. HCFA plans a short education phase following release of the guidelines and will then begin using the guidelines for pre and post payment claim audits in early 1995.

Understanding the documentation requirements is as important as understanding the codes when they were introduced in 1992. Every physician is encouraged to attend this workshop. Staff are welcome but should not attend in place of physicians.

All five programs are scheduled from 6:00 p.m. to 8:30 p.m. and will be preceded by a buffet dinner. Cost for the dinner and program is $50/member and $75/nonmember.

The programs will be held Wed., Nov. 2 in Cedar Rapids; Thurs., Nov. 3 in Des Moines; Wed., Nov. 9 in Davenport; Wed., Nov. 16 in Sioux City; and Thurs., Nov. 17 in Mason City.

Program details and registration information will be mailed directly to all members. For more information, call Mary Reinsmoen at IMS, 515/223-1401 or 800/728-5398.

AT A GLANCE

IMS has available a list of magazines which do not accept tobacco advertising. The IMS Services Magazine subscription service also contains the "no tobacco advertising" designation. For a list of magazines, call Chris Clark at IMS, 515/223-1401 or 800/747-3070.

The Iowa Department of Public Health is working on implementation of an electronic birth certificate process and has begun testing of the software in 25 Iowa hospitals which have 400 or more births every year. Following this phase, the DPH will offer the software to hospitals that deliver 100 babies each year. For more information, call Rose Mary Hicks at the DPH, 515/281-4952.

Upcoming Workshops for You and Your Practice

Billing and Collection Strategies

Tuesday, October 18	West Des Moines
Wednesday, October 19	Davenport
Thursday, October 20	Sioux City

Office Team Skills

Tuesday, October 4	Mason City
Wednesday, October 5	Dubuque
Tuesday, October 11	Spencer

Retirement Seminars

Wednesday, October 5	Ottumwa
Thursday, October 6	Cedar Rapids
Wednesday, October 12	Marshalltown
Tuesday, October 18	Iowa City
Thursday, October 20	Waterloo
Tuesday, October 25	Mason City
Wednesday, October 26	Burlington

For more information on any seminar, call Mary Reinsmoen or Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

MIDWEST MEDICAL INSURANCE COMPANY FOCUS ON RISK MANAGEMENT

Terminating physician-patient relationships

When a physician or clinic agrees to treat a patient, a duty to continue treatment is created and exists until the relationship is terminated. The relationship can be ended by mutual consent, at the request of the patient or after the physician has given the patient notice and reasonable time to find another physician. Failure to give sufficient notice may result in charges of abandonment.

Physician-patient relationships end for many reasons. To minimize the risk of liability in terminating service to patients:

- Carefully evaluate the medical status and needs of the patient to ensure that the patient will not be harmed by termination of services.
- Assess the availability of alternate care.
- Send a letter with return receipt requested informing the patient that services are being terminated, continuing care may be necessary and emergency care will be provided between the date of the notice and the date of termination. Including the name and number of a physician referral service is also advisable. To expedite transfer of care, include an authorization form for release of medical records.

MMIC generally suggests patients be given 30 days notice before services are terminated. Several factors must be considered in determining sufficient notice.

Physicians and clinics are encouraged to seek the advice of their attorney or professional liability insurance carrier when terminating patient services. Contractual relationships with third party payers also affect how relationships can be terminated.

For futher information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

MMIC generally suggests patients be given 30 days notice before services are terminated.

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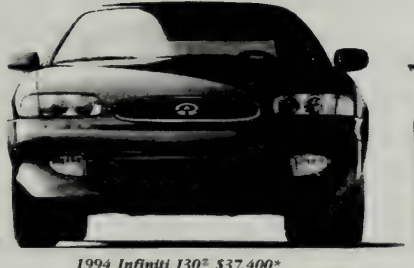
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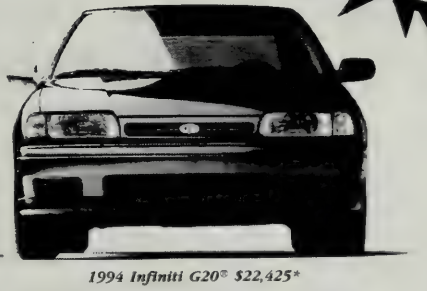


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Newsmakers

Awards, appointments, etc.

The following physicians recently joined McFarland Clinic, Ames: **Dr. Jay Brown,** allergy and immunology; **Dr. Kevin Crowe,** cardiology; **Dr. Bryan Graveline,** gastroenterology; **Dr. Perry Rathe,** family practice and **Dr. Gregory Utesch,** anesthesiology. **Dr. Thomas Menzel,** general surgery, has joined the McFarland Clinic branch offices in Boone and Jefferson. **Dr. Richard Vermillion,** longtime Ogden family physician, recently joined McFarland's Ogden branch office. The Mercy Clinic System has expanded its services throughout the Des Moines area by adding three clinics and six physicians: Mercy Norwalk Medical Clinic, **Dr. Christopher White** and **Dr. Larry Standing;** Mercy Park Medical Clinic (Des Moines), **Dr. Dennis Zachary** and **Dr. James Brown;** Mercy Pleasant Hill Medical Clinic, **Dr. Charles Korte** and **Dr. Eden Murad.** Three Waterloo area hospitals, under the guidance of the Black Hawk County Medical Society and **Dr. Roswell Johnston,** president, held their first joint monthly medical staff meeting last spring. Approximately 130 physicians from Allen Memorial Hospital, Covenant Medical Center and Sartori Memorial Hospital attended the meeting. According to **Dr. David Kabel,** president of Allen Memorial Hospital medical staff, "Doctors expressed an interest to demonstrate to the community that they want to be a more unified group than in the past." Not surprisingly, the issue most talked about is health system reform, say **Dr. Robert Singer,** president of Covenant Medical Center medical staff and **Dr. James Young,** president of Sartori Memorial Hospital medical staff. Mercy Hospital Medical Center, Des Moines; Mercy Clinics of the Des Moines metro area; and Mayo Graduate School of Medicine, Rochester, Minnesota, are developing a fully accredited family practice residency program in Des Moines. Starting in July 1997, six residents will be accepted each year to the three-year program. The Cardiovascular Research Center at UI College of Medicine has been internationally recognized for its hypertension research by the International Society of Hypertension in Melbourne, Australia. The Merck, Sharp and Dohme International Award was presented to **Dr. Francois Abboud, Dr. Gerald DiBona, Dr. Donald Heistad** and **Dr. Allyn Mark.** The MSD Award is presented biennially to a person, persons or institution responsible for distinguished work relating to the etiology, epidemiology, pathology or treatment of hypertension. **Dr. Lisa Hazelton,** Cedar Rapids internist and **Dr. Robert Silber,** Cedar Rapids gastroenterologist/internist, have been elected fellows of the American College of Physicians. **Dr. John Cowdery,** professor of internal medicine and **Dr. Larry Tobacman,** associate professor of internal medicine, UI College of Medicine, were among 80 researchers selected nationwide for membership in the American Society of Clinical Investigation. **Dr. James Collins,** retired Waterloo pathologist, has loaned his collection of old and rare cars to the National Farm Toy Museum in Dyersville. Over 300 vehicles comprise the cast-iron car collection. Dr. Collins and his interesting hobby are featured in the May 1994 *Toy Farmer* magazine. **Dr. Peter Kirchner,** professor of radiology and internal medicine at UI College of Medcine, received the Gorgy Hevesy Memorial Medal from the Hungarian Society of Nuclear Medicine. The prize is named for a Hungarian Nobel laureate. Dr. Kirchner was also elected vice chairman of the American Board of Nuclear Medicine. **Dr. William Galbraith,** associate of internal medicine at UI College of Medicine, received the 1994 Internist of the Year Award from the Iowa Clinical Society of Internal Medicine. The award recognizes excellence in practice and community service. **Dr. M. Paul Strottman,** associate professor of internal medicine at UI College of Medicine and staff physician at UI Hospitals and Clinics, received the Dr. Ernest O. Theilen Clinical Teaching and Service Award. The annual award is presented to a clinical faculty member who demonstrates dedication, unselfish advocacy of the College and is considered an honored mentor and distinguished representative of the UIHC. IM

AT A GLANCE

The American Academy of Family Physicians has honored the UI College of Medicine for producing a high percentage of graduates who enter family practice careers. The College received the Bronze Achievement Award from the Society of Teachers of Family Medicine. The three-year average of medical students entering family practice residency programs was 22.7%. Of the 1994 graduating class, 32% selected family practice.

Impaired physicians may find help with substance abuse problems through groups such as Siouxland International Doctors in Alcoholics Anonymous (IDAA) and Caduceus Alcoholics Anonymous. Caduceus AA meets Mondays at 6:30 p.m. at 1313 High Street, Room 320 in Des Moines. Call Dr. Stan Haugland at 515/241-6021 for more information. Siouxland IDAA meets Tuesdays at 7 p.m. at Trinity Lutheran Church, 1122 Jackson Street in Sioux City. Call 712/279-3975 for more information.

Don't shoot the messenger

Physicians' greatest fear is about to happen. After years of fretting about the dangerous and impersonal idea of using computers in clinical diagnostics, the interactive knowledge superhighway is about to give physicians a wake-up call.

It was my honor recently to participate in a task force appointed by the new Health Commons Institute, created by family physician Dr. Richard Rockefeller to find better computer applications in patient care.

As a practicing physician, Dr. Rockefeller knew complex paper algorithms designed to assist physicians with the daily practice of medicine weren't selling. He courageously began discussion of the hidden secret in family medicine—we can't keep up.

Our group, which I called the "Rock Group", began to understand medicine is never going to be the same again. Our prophesy was that "knowledge systems" will soon be written in non-technical language to enable patients to get medical advice through their cable TVs at home. They can record medical information in their computer "file" and this file will be accessed by health professionals to further assist the patient with accurate diagnostic and therapeutic information. Therapies, billing information, quality checks, cost advisories and further indepth information will all be available and will enable each patient to share in decisions about their own health care.

The worrisome thing is that this is about to happen without doctors involved. In general, doctors and other health care professionals are losing control of the health care delivery system. The cognitive support of knowledge systems may further assist patients and primary care providers to jointly manage the total health of an individual.

Doctors will have to work hard to keep up with questions from consumers armed with cable interactive diagnostics and CD ROM personal health managers.

Therefore, the medical profession must push for good, easy-to-use, interactive diagnostics for the practitioner. In fact, physicians need to begin defining a whole new technologically advanced role or risk becoming outdated.

The medical profession must push for good, interactive diagnostics for the practitioner.

Family doctors should be first to demand physician-friendly computer support for diagnostics. Good clinical observation skills are still critical. Family doctors' time must be spent examining patients, comforting suffering and coordinating the case management—not looking up references, referring cases to specialists unnecessarily or looking stupid to well-informed patients.

Please don't shoot the messenger. These technologies are happening with or without us. The Health Commons Institute is giving us a window into the future that will creat opportunity for physicians. It is imperative that we, at last, befriend the feared computer and make it work for us. IM



STEPHEN GLEASON, DO

Dr. Stephen Gleason is a Des Moines family physician and chief medical officer for Mercy Clinics, Inc. He continues to serve as White House advisor and senior consultant to the U.S. Department of Health and Human Services.

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Congress may be at a standstill, but health system reform is happening

Do you have a plan for the future of your practice? The Iowa Medical Society's statewide conference "Organizing for Change" can help you explore your options

As part of the Iowa Medical Society's Futures program, a statewide conference "Organizing for Change" will be held especially for Iowa physicians on Thursday, October 27 in Des Moines. The conference is geared toward physicians who want to plan their strategy in the new world of health care delivery. The conference will focus on ways to cope with the new environment and plan for the future. Expert consultants will offer advice on evaluating and negotiating contracts in Iowa, financing arrangements, capitation and other key issues. Dr. James Todd, AMA executive vice president, is a special guest and will be the keynote luncheon speaker. To register for the conference, just fill out the form, tear it off and send it to IMS headquarters. For additional details on the conference, call Barbara Cannon or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

Registration form • Statewide Futures program

YES I will attend the Iowa Medical Society's conference "Organizing for Change"
Thursday, October 27, 8:30 a.m. - 4:30 p.m.
Marriott Hotel, Des Moines
REGISTRATION FEE: $80 for members
(Includes lunch) $125 for nonmembers

Name _____ IMS member? Yes ____ No ____

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Clip out and mail to the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 ATTN: Barbara Cannon. A check for your registration fee must be enclosed. Registration deadline: October 18. If you want to stay the night, please reserve your room directly with the Marriott Hotel, 515/245-5500.

Look on pages 440-447 of this *Iowa Medicine* for articles on physician contracts and capitation written by consultants who will speak at the Iowa Medical Society's "Organizing for Change" conference.

FUTURES

Managed care contracting: a road map around potholes

NOTE: This article was written by W. Kenneth Davis, Jr. of the law firm Jenner & Block in Chicago. Mr. Davis has examined many Iowa physician contracts and will be a guest speaker at the Iowa Medical Society's October 27 Des Moines conference "Organizing for Change".

What is Managed Care?

Managed care is broadly defined to encompass any arrangement involving purchase or provision of health care in a manner that is not fully patient-directed; any mechanism, plan or process structured to focus on price, quality and utilization.

Like death and taxes, managed care is a certainty. Most people believe managed care will continue to expand in states such as Iowa where it is not yet as pervasive as in other states. However, opinions on what (or whether) health system reform will be approved vary dramatically. In any event, it is certain managed care will play a role in the rapid transformation of the health care industry.

Managed care — a working definition

"Managed care" is broadly defined to encompass any arrangement involving the purchase and/or provision of health care in a manner that is not fully patient-directed. It encompasses any mechanism, plan or process structured to focus on the price, quality and utilization of services and the site where services are received.

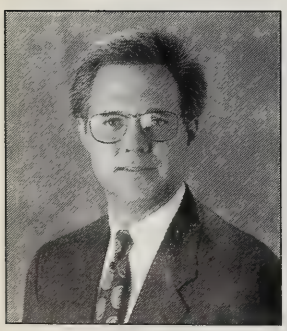
Managed care presents a continuum of health care options. At one end, managed care might by a simple pre-authorization requirement for inpatient stays. At the other end, it might involve an HMO or other managed care organization which requires enrollees to select a primary care "gatekeeper" for consultations with other specialists and for diagnostic testing.

What does managed care mean for physicians?

Contracting with a managed care organization, known as "participating in managed care", has a number of implications for physicians. Physicians have less control over how health care is provided and generally lose some of their traditional autonomy. Income levels may decrease depending on patient volume.

There is a move from fee-for-service reimbursement to capitated or package-priced reimbursement, even for specialists. Ultimately, managed care contracting means physicians are forced to focus, probably more heavily than they care to, on what have been viewed as business issues.

All physicians, including primary care and other specialists, face a number of difficult issues. Many of these issues are closely tied to the proliferation of managed care and to the potential major reform which the health care industry faces. So, what should physicians be doing to plan for the future?



W. Kenneth Davis
Mr. Davis is a health care attorney who focuses on all aspects of managed care. He has represented physicians in managed care contracting and in development of physician-sponsored organizations.

Unfamiliar challenges

Because of the unfamiliar challenges they are encountering, physicians need to be more circumspect in their approach to the business of medicine. Physicians should analyze the current market and consider where it may be heading. They should take a close look at their practices and personal lives and make a plan which is consistent with their professional and personal goals. Having developed a strategy, physicians are in a better position to know whether a particular managed care contracting opportunity makes sense for them.

Looking at per patient costs

Although physicians may hold different visions of the future, no physician can deny the importance of the need to understand and reduce per patient costs. This has resulted from health care's rapid change from predominantly fee-based reimbursement to what can best be termed "cost-based" reimbursement. Under fee-for-service reimbursement, physicians participating in managed care organizations, Medicare or Medicaid were concerned with how much they were discounting their "usual and customary" fees.

Increasingly, payers are asking physicians to accept packaged fees or capitated payments. These reimbursement arrangements mean relatively fixed per patient revenue levels. With revenue levels fixed and with fewer opportunities to enhance revenue through other sources, physicians must keep a closer eye on costs.

Becoming attractive to "customers"

Applying economic terms to a medical practice, physicians have at least three types of "customers" — patients, referring physicians and payers such as managed care organizations. Recent studies have shown it is possible to evaluate patient satisfaction and identify ways to improve it. Likewise, referring physicians need to feel comfortable with their referral. They must feel their relationship with the physician will be effective from a patient care standpoint. Referring physicians generally have fewer referral options under managed care but usually have some choice. Finally, managed care organizations will be attracted to the physician who provides high quality medical care, is accessible to patients and is cost-competitive.

Managed care organizations will be attracted to the physician who provides high quality medical care, is accessible to patients and is cost-competitive.

Preparing for capitation

Increasing numbers of managed care organizations are requiring participating physicians, including specialists, to provide services on a capitated or package-priced basis. Under capitation, a physician's monthly income is fixed, regardless of the number of times the physician sees a patient or the number of procedures the physician performs. The physician assumes the major portion of the risk of serving a patient population with a high morbidity level.

Physicians should understand that it is possible to analyze the financial viability of

accepting whatever capitation has been offered. However, physicians must have a firm grip on costs in order to determine whether the capitation will enable them to cover those costs.

It becomes even more important to maintain good management information systems for analyzing their existing precapitation patient population and calculating the net effect of replacing fee-for-service with capitated payment. A good management information system will be useful for tracking referral patterns and identifying physicians who are ordering an unusual number of tests or inappropriate procedures.

If a court finds cost considerations inappropriately affected medical decisions, everyone could be held liable.

Managed care and liability concerns

Physicians face many issues when they enter into a contract with a managed care organization. These issues generally fall under two headings — professional liability concerns and concerns over specific provisions of the proposed contract.

There is a potential conflict between quality patient care and "cost-containment" provisions seen in managed care contracts. These items are not mutually exclusive because some cost-containment measures can increase quality of care. However, certain cost-containment provisions can interfere with clinical decisions.

The legal and policy implications of this potential conflict are beyond the scope of this article. However, despite the trend toward rewarding physicians on the basis of economic implications of their treatment decisions, physicians must be very careful with regard to how they let economics affect their practice. If a court finds cost considerations inappropriately affected medical decisions, everyone could be held liable.

Physicians should take several precautions:

- Never deviate from the standard of care applicable to your type of practice.
- Document all treatment decisions.
- Challenge any utilization review decisions that conflict with your medical judgment; pursue all avenues of appeal to the fullest extent.
- Document all contact with utilization reviewers and managed care organization administrators.
- If necessary, advise patients of your non-concurrence with external review decisions.
- Always maintain liability insurance.

The contract

The first and most important piece of advice is to read the contract. Do not enter into a contract unless it makes good business and personal sense. These are issues to consider in making this determination:

- What is the financial state of the managed care organization?
- What are the administrative capabilities of the managed care organization?
- What are the physician's responsibilities under the contract?
- How and how much will you be paid?

•What is the term of the contract and does it include an "evergreen clause"? An evergreen clause requires automatic renewal at the end of each year and can cause problems when rates and fee schedules are not updated to account for inflation.

•How can the contract be terminated and what are the continuing treatment obligations of the physician upon termination?

•Does the physician have access to any due process rights upon termination?

•Does the contract contain practice restrictions? Restrictions such as non-compete convenants can have a devastating synergistic effect with the contract's termination provisions. Specifically, if the managed care organization terminates the physician, the non-compete convenant might prevent the physician from contracting with another managed care organization to replace the patients the physician will lose from the first managed care organization. If the physician treats many patients from the managed care organization, the effect on that physician's practice could be devastating.

•Does the contract contain a hold harmless/indemnification clause? Generally, these types of provisions state that the physician will be responsible for and will "hold harmless" the managed care organization for any losses the organization incurs as a result of the physician's action. The net effect of an indemnification clause is that it shifts liability to the treating physician if a problem arises, even if the physician was cooperating with the decisions or procedures recommended by the organization or its utilization reviewers.

Physicians should be aware that many, if not most, professional liability carriers view this type of clause as assumed contractual liability, which they exclude from coverage. Therefore, if the physician agrees to an indemnification clause, the physician could become personally liable.

If the physician agrees to an indemnification clause, the physician could become personally liable.

•Does the contract incorporate other documents or materials "by reference"?

Go forward carefully

Managed care contracting should not pose insurmountable problems, but physicians need to be wary when approached by a managed care organization. First, make sure the proposed contract makes good business sense. If it does, carefully consider the professional liability implications and specific contract provisions. By following a methodical, reasoned approach to contracting, physicians stand a better chance of coping effectively with managed care.

Turn to the next page for an article on how to prepare for accepting capitation payment.

FUTURES

Preparing for capitation

NOTE: This article is excerpted from a presentation by consultant William DeMarco to the National Association of Managed Care Physicians and the American Association of Physician Hospital Organizations earlier this year. Mr. DeMarco will be a guest speaker at the Iowa Medical Society's October 27 Des Moines conference "Organizing for Change".

What is "Capitation"?

Capitation is a way to pay for health care services in which physicians and other providers accept a fixed payment per subscriber, per period of time, in exchange for specified services.

The public policy debate over health system reform will continue, but many of the decisions have already been made without any physicians in the room. The regulated fee-for-service environment we have all known is history.

When you start looking at employment figures in your local area, I don't care if you're in Boston or Keokuk, the small employers are the ones hiring. The small employers are the ones getting killed with increasing health care costs and aggressively looking for ways to experiment with different relationships.

Don't risk being locked out

Though many physicians fear the group practice arrangements which make other reimbursement structures possible, there is a danger in doing nothing. Some physicians in Orange County, California told me recently they're fighting each other over Medicare and Medicaid because that's all that is left in their market. These physicians waited until the last minute to get into managed care arrangements and were locked out.

During the American Revolution, George Washington's surgeon received a prepaid contract to take care of all the people on his plantation. Obviously, capitation is not a new concept. However, it is coming into prominence because employers are frustrated with the cost of medical care and are moving toward fixed costs and accountability. Physicians are forced to accept that employers are looking toward capitation as a way to control costs and it is very difficult to change employers' attitudes about reimbursement.

Reimbursement dictates the structure of your group practice. If you are in the process of developing a PO or PHO, being able to identify what kind of reimbursement will be the most attractive in your market will identify how you bring physicians together around a very delicate issue. Reimbursement systems can create conflicts within the organization that cannot be resolved until the structure is changed.

Why group practice?

The question physicians everywhere are asking is how they can re-engineer their practices to prepare for capitation. Though the obvious answer is group practice, there are many definitions of group practice. In my experience, a strong case can be made to a large employer for contracting directly with a group practice. Why? Because of the way



WILLIAM DEMARCO
Mr. DeMarco is president and CEO of DeMarco & Associates in Rockford, Illinois. The firm offers a variety of services to physicians, including organizational development, marketing strategy and operational planning and effectiveness.

those physicians practice, because of the culture they can create, because of the types of physicians in the group. The best group practice is a team of physicians with separate skills but a common philosophy which benefits patients. You may not see walls, but you see a common bond of philosophy and mutual trust.

If you are trying to develop a PO or a PHO, these are values that will help you accomplish your goals. That's a Mayo Clinic-type group practice, which many of my clients say is the kind they want to set up.

"That's a Mayo Clinic-type of group practice, which many of my clients say is the kind they want to set up."

Selling is 'fraught with risk'

Many hospitals are approaching primary care physicians and offering them very attractive salaries. But, many attorneys have shown us that this approach is fraught with risk unless the physicians first sell their practices to a Physician Organization. In a PO, a senior physician who wants to retire could be replaced by a fresh young physician and the group won't lose any portion of the market share to the competition. So, you're actually building and retaining the relationships in the delivery system.

You can accomplish all this without one single facility; you can have a group practice without walls. This gives you leverage in the managed care environment. When the hospital or managed care company want to negotiate, they will look for a group practice (with or without walls) to work with.

I'm not describing Nirvana to you. These are opportunities to blend with the New World and to really focus on practice control in an area where physicians are most comfortable — clinical medicine. Strong leadership is required to meld individual players to group practice behavior. You can put together a structure today but it might be six months before you really have a group practice in place. It takes time, but it's worth the investment.

Create and adhere to a business plan

As a group, the physicians must create and adhere to a business plan. This is new for many physicians. The group must operate a delivery system capable of tying compensation and performance with monetary and non-monetary rewards. The focus is on capitation, and there are tremendous benefits in developing a group practice structured toward capitation payment. Employers are particularly looking for multispecialty groups.

One way to do this is to buy all the practices and be done with it. The other way is a more transitional approach. It involves the ability of five to 10 physicians to sit down in a room and say we know each other but not real well and we need to understand everyone's decision-making process, the legal applications and where we can go from here. This can all be done following a step-by-step approach.

As a first step toward group practice, you can save dollars by consolidating such items as managed care billing and negotiations. Then you can consolidate administration, clinical supplies and insurance. Next, the group can move into the areas of office overhead and lab

fees. The final biggest step is consolidating physician income, though we have found that by the time a group gets to this step it's not as big an issue as we thought it would be.

One advantage to the transitional approach toward group practice is it requires much less up-front capital. It does require more capital than doing nothing, but if you're losing money from managed care or you're being locked out, doing nothing could eventually cost you a lot more.

At first glance, some hospitals see high risk in employers and physicians coming together.

Physicians shouldn't feel pushed

Using the transitional approach, standards are set for participation and it allows for broad time frames. If physicians feel pushed through the transition in two or three months, it could be World War III. It is much better if the transition period is a year or even two years. The group might make a decision that in a certain period of time they'll go to a higher level of integration and at that point if someone wants out, the group can buy their stock. The point is, you're developing direction and momentum.

If you are going to a group practice in a capitated environment, you are now in the world of business and you need to have an insurance company or HMO license.

Another interesting approach we are seeing is a PO contracts with the payer and the payer contracts with a Managed Service Organization (MSO) to handle the billing and administration. The hospital and health system are part owner or have some kind of contractual relationship.

Yet another option is the physician group actually contracts with the employer and the physician-employer joint venture contracts with the hospitals. Providers create an MSO and then contract with an employer and a hospital. Or, the providers and the employer create a new corporation that contracts with hospitals. At first glance, some of the hospitals see high risk in employers and physicians coming together.

However, after some discussion what we have seen is that MSOs can be helped by the hospitals, either through a loan or through start-up costs. When the MSO contracts with the employer/physician organization and with the hospital, it's possible to start looking for other specialists and other services you can arrange for.

You supply claims information for employers

This brings in a whole new pool of capitated funds which weren't available before. The employers are paid $3-$10 per employee per month for cost containment, and where do you think they get the claims information? From you. The insurance companies are aggregating the data from your billing, packaging it and selling it back to the employers. The employer already has funds allocated for cost-containment, so why not take those dollars and invest them?

This is one of those models that probably started out on a napkin in a hotel restaurant and wound up as a local delivery system The providers are running cost-effective care in

exchange for market shares. The purchasers get cost-effective care by buying value. The value in this case is determined not by purchasers but by the physicians and hospitals.

Edge into capitation through case management

This model can be started in small and large markets. I think many of us have been told that managed care companies and insurance companies and employers are the enemy, but that's not true. I believe many employers realize standards of care and clinical guidelines aren't things that can be purchased but are things they need to work through.

Some of you who are in an environment where you are starting to experiment with capitation, there are employers who approach hospitals for packaged obstetric or cardiac services — all the services they use regularly. These employers are trying to get their arms around what these products look like. This is a good way for physicians to edge into capitation. If a group of physicians can control costs in a case management style, they can do something on a broader basis with all employees.

Starting to blend relationships

The managed care arrangements in some places are becoming very sophisicated and the concept of capitation favoring the group model and staff models is very real. If you're not quite there yet, if an IPA or a joint venture or a simple service bureau will do in your market, at least you are starting to blend those relationships. You are beginning to come together on some of the things employers and patients are looking for.

Watch next month's Iowa Medicine *for the second part of Mr. DeMarco's article on capitation.*

In the November *Iowa Medicine*, William DeMarco discusses how to make the most of capitation. Mr. DeMarco is a consultant who will speak at the IMS Oct. 27 conference "Organizing for Change".



FRONT ROW: Ruth Clare, Bernie Lowe, Mary Sievers
BACK ROW: Terri DeGroot, Don Neumann, Patty DeFrancisco

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The Journal
of the Iowa Medical Society

Leptospirosis: a consequence of the Iowa flood

● LAURENCE FUORTES, MD; MARY NETTLEMAN, MD

Leptospirosis is one of the most common zoonoses in the world. Also known as Weil's disease, swamp fever, mud fever or Swine herd's disease, leptospirosis results from direct or indirect exposure to urine of infected animals. Both domestic and wild animals may act as reservoirs excreting the spirochete in their urine. Though cattle and swine are the main livestock species infected, sheep, goats and dogs may also excrete the agent. Wildlife reservoirs include rats, squirrels, raccoons, mice, shrews, foxes and others.

Exposure may occur directly to the urine or indirectly through contaminated water. This disease has been recognized as an occupational infection among sewer workers, with the first apparent outbreak thereof being described in 1883.[1] Occupational infection has been described among coal miners (exposure to rats), farmers (exposure to livestock), people working in contaminated rice paddies, veterinarians, abattoir workers, hunters, trappers, swimmers and kayakers.[1-5]

The floods of 1993 led to extensive loss of property and crops in nine midwestern states including Iowa. The public water supply of Des Moines was disrupted for several weeks, 29 of Iowa's 99 counties reported flood damage to public water systems and 31 of Iowa's counties reported flood damage to their sewer systems. Much of the Iowa land affected by the flood was farmland, thus creating the potential for contamination of surface waters from both municipal and agriculture sewage.[6] This article discusses two cases of leptospirosis among residents of Iowa City with exposure to flood waters diagnosed in the University Hospital Outpatient Clinics.

Case Number 1: On July 23, 1993, a 44-year-old female was admitted to the hospital with the diagnosis of Leptospira meningitis. She related an acute illness developing July 17 with fevers to 103 degrees, myalgias and arthralgias. There was little response to a short course of doxycycline given initially. Approximately eight days after the onset of illness, she experienced a severe global headache with photophobia and emesis.

She lived near the Iowa River and for several weeks her home was essentially surrounded by water. She related extensive work around her home which involved wading through and cleaning up flood waters. The family drank only bottled water. Her daughter suffered a febrile illness which lasted approximately four days. On physical exam, the patient was in moderate distress with a temperature of 38.3 degrees centigrade, mild meningismus and photophobia. Otherwise the exam was unremarkable.

Laboratory analyses revealed elevated liver function tests, ALK PHOS=347, AST=62, GGT=236, and erythrocyte sedimentation rate of 105. White blood cell count and differential were within normal limits. Urinalysis revealed 3-4 white blood cells and 1-2 red blood cells for high power field. Lumbar puncture revealed CSF glucose at 55 and protein at 52, red blood cell count of 20, white blood cell count of 210 with 23 lymphocytes, 164 neutrophils and 23 histiocytes. CSF darkfield examination and cultures were negative. Patient was treated with IV penicillin with resolution of her clinical syndrome. Her leptospirosis titers were positive for Leptospira grippotyphosa 1:1600, Leptospira jasmine 1:800, and Leptospira bratislava 1:400, and Leptospira australis 1:200.

Case Number 2: A 39-year-old male came to the emergency room on August 16, 1993 complaining of a two-day febrile illness with temperature up to 40 degrees centigrade,

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for October 1994.

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Leptospirosis: a consequence of the Iowa flood

continued

myalgias, rigors and delirium. The patient's CBC was within normal limits; his urinalysis revealed 2+ protein, 3-4 white blood cells and 1-2 red blood cells per high power field. The patient was treated empirically with Bactrim for urinary tract infection and seen the following week in the outpatient clinics. The patient relayed defervescence while on the antibiotic and antipyretics. He subsequently developed a severe constant bifrontal headache. He related living in a flooded area of the community and had extensive contact with flood waters traveling to and from his home and in cleaning up flood damage.

Acute phase titers for leptospirosis were positive L. jasmine at 1:400, L. bratislava at 1:200, and L. grippotyphosa at 1:100. A repeat titer one week thereafter revealed markedly elevated titers with L. jasmine titers of 1:3200, L. bratislava titers 1:6400, L. grippotyphosa titers 1:800. The patient was treated with Doxycycline and his clinical syndrome promptly resolved. Follow-up titers one month after treatment with Doxycycline revealed negative Leptospira serology.

Discussion of the cases

The authors report two cases of non icteric leptospirosis. Both cases were suspected on the basis of extensive flood water exposure and a biphasic illness with characteristic aseptic meningitis as a later phase of illness. Both cases were confirmed by serology. Conjunctiva suffusion, a characteristic feature of the early stage of the illness, was not described in either of these cases. Both cases responded promptly to antibiotic treatment with no residual impairment.

The spectrum of human illness from leptospirosis ranges from an anicteric generalized febrile influenza-like syndrome with malaise, myalgia, meningeal symptoms and conjunctivitis in 90% of cases to more severe cases with renal and/or hepatic involvement. Although hepatorenal syndrome may occur with a fatality ratio of 20 to 40%, hepatic and renal function generally return to normal. Typically the illness is biphasic with an incubation period of approximately 10 days. The acute or leptospiremic state is characterized by acute onset of a febrile illness lasting days to weeks. The second stage, following several days of defervescence, is manifest by severe headache and meningismus. The diagnosis may be made by serial leptospirosis serologies (microscopic agglutination), darkfield microscopy and blood or CSF culture in the acute phase or urine culture in the second benefit as a prophylactic treatment in conjunction with personal protection.

Surveillance by the Iowa Public Health Service in July revealed no serious flood-related infectious diseases. We believe the extent of zoonotic disease transmission in floods may be grossly underestimated because these diseases are not widely screened for. There have been three serologically proven cases of leptospirosis in Johnson County since the flood and only seven cases in the preceding 12 years.

An outbreak of leptospirosis occurred in Greater Recife, Brazil after flooding in July, 1975. Of 107 reported cases, 105 were confirmed by blood culture or microscopic agglutination serologies.[7] In another study, rainfall was clearly associated with 248 confirmed leptospirosis cases diagnosed in Barbados between 1979 and 1986. The incidence of leptospirosis in areas with greater rainfall than 160 cm was twice that of areas with less than 160 cm. Similarly, the most severe cases appeared to cluster after periods of heavy rains.[8] In future flooding, leptospirosis and other zoonotic disease should be considered in the differential diagnosis of febrile disease states associated with some combination of myalgia, sterile pyuria, low grade hepatic enzyme elevations and meningitis.

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IMS . . . working for Iowa physicians and their patients

With a membership of over 4,100, the Iowa Medical Society (IMS) represents about 82% of the medical profession in Iowa. Included with membership are many benefits, both tangible and intangible.

These benefits are wide-ranging and designed to meet both individual and group practice needs. They encompass insurance coverages such as professional liability, health, life, disability and workers compensation; administrative assistance to medical specialty societies; financial and retirement planning services; practice management programs; debt collection and long distance telephone service.

Besides receiving a subscription to *Iowa Medicine,* members also get the annual IMS Membership Directory. Members receive copies of publications published by the IMS, e.g., the "Physician's Guide to Iowa Law" and the "Physician's Guide to Medical Records".

These benefits are wide-ranging and designed to meet individual and group practice needs.

Members receive many intangible benefits, some of which are the result of efforts by IMS physician committees and staff. These include representation in the Iowa Legislature, the Governor's office, state agencies and with third party payers. Physician contributions to IMPAC, your bipartisan political action committee, help support IMS efforts to work with state-elected officials in ensuring they understand how health system reform will affect you and your patients' best interests.

Three years ago the IMS embarked on a strategic planning process which is continually updated to focus on physician needs. The ***Futures*** program is the latest initiative resulting from this process. ***Futures*** is designed to educate and assist physicians in exploring their options and formulating a viable plan for the future. Aside from ***Futures,*** the IMS will be helping physicians respond to issues affecting medical practice, such as CHMIS, HEDIS, telemedicine and health system reform.

Participation in nearly all of the benefit programs endorsed by the Iowa Medical Society requires membership in the IMS. In Iowa, membership is unified at the county and state levels. In order to belong to the IMS, a physician must also belong to his or her county medical society and vice versa.

According to IMS Articles & Bylaws, membership is under the direction of the Judicial Council. The Judicial Council is comprised of 15 physicians representing the 15 councilor districts. Pursuant to action of the 1993 IMS House of Delegates, four Councilors have appointed Deputy Councilors to assist them.

Because the 1994 IMS House of Delegates eliminated the Grievance Committee, the Judicial Council is now assuming the duties and responsibilities of the Grievance Committee. Whenever possible, initial investigation is handled by the county medical society or individual Councilor. Grievances are received from the general public and physicians. Most grievances result from miscommunication or failure to release medical records. IM

Membership questions may be directed to Sandy Nelson or Sheryal Westbrook at IMS headquarters; 515/223-1401 or 800/747-3070.

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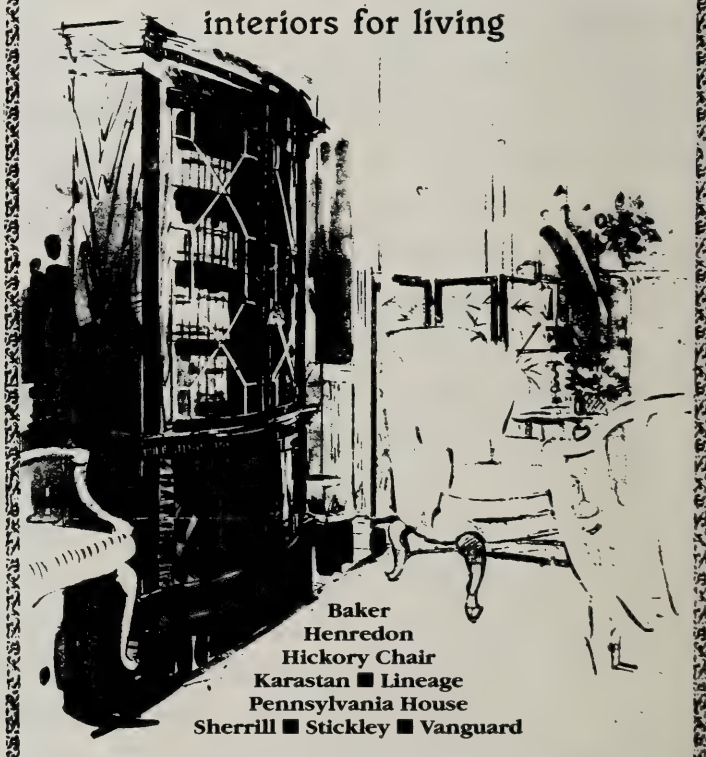
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The Book of Virtues is highly recommended

Whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report: if there be any virtue, and if there be any praise, think on these things.

Philippians 4:8

It is unfortunate that traits which are the elements of good character have become lost in many segments of our society. We continually witness breeches of good character demonstrated by persons in high positions as well as other segments of our culture. The lack of virtue is not new. Paul the Apostle obviously was concerned by his admonition to the people of Philippi during the first century. Luke the physician travelled with Paul on some of his missions so undoubtedly was a recipient of these teachings as well.

A new best-seller called *The Book of Virtues* is an excellent anthology on the nature of virtue. William J. Bennett has produced a monumental work that should be in every home. Bennett is the former director of the Office of National Drug Control Policy under President Bush and secretary of education under President Reagan. He now serves as co-director of Empower America, as Distinguished Fellow in Culture Policy Studies at the Hermitage Foundation and as senior editor of *National Review* magazine. *The Book of Virtues* is a collection of hundreds of stories comprising a rich mine of moral literacy. The stories exemplify the virtues of self-discipline, compassion, responsibility, friendship, work, courage, perseverance, honesty, loyalty and faith. Each chapter is prefaced by introductory comments on the general subject matter. Many of the stories are accompanied by a short comment of the gist of the story, adding much value to the story.

This is not a book to be read from cover to cover as one would a novel or history. It can serve as a reference, a reminder to the reader of virtues to which we should adhere and an anthology to educate our children. Keeping this book close at hand and reading several sections each day can be inspiring as well a thought-provoking.

Virtue is so all-inclusive that it should control our entire life pattern. We as parents and as physicians have a great responsibility to inculcate the tenets of virtue in others. If we fail to practice virtue, fail to teach our children and demonstrate to others by our own actions, we fail to fulfill our destiny.

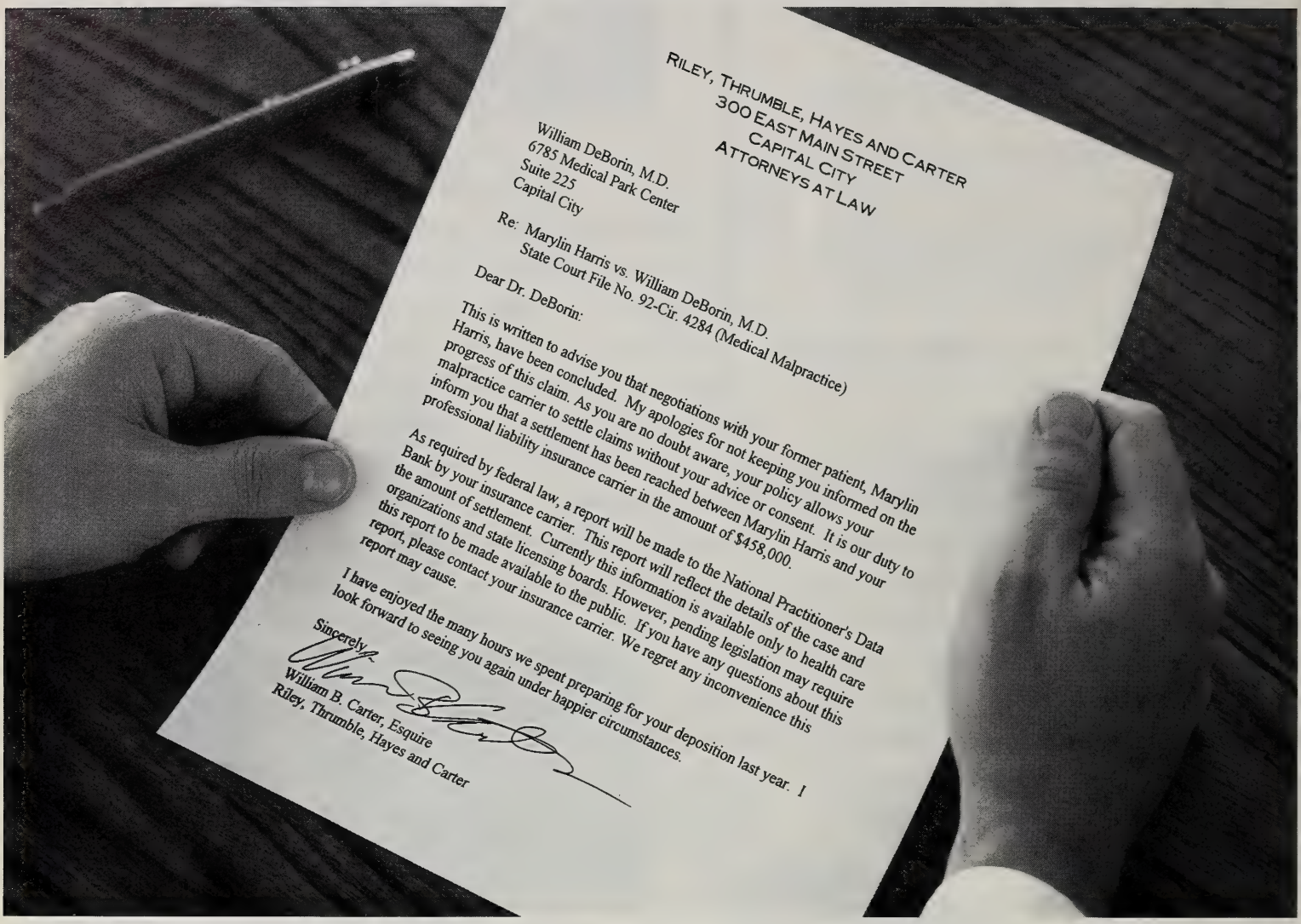
If we fail to practice virtue, we fail to fulfill our destiny.

I hope I have convinced my readers to procure a copy of *The Book of Virtues*. Better yet, give a copy to each of your children. IM



Marion Alberts, MD

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William DeBorin, M.D.
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Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
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At this writing, Congress continues to grapple with health system reform legislation. Should any law be enacted, it is unlikely the event will occur until sometime during the autumn.

Among the several "side-by-side" comparisons of legislative proposals under consideration, there is a recent 23-page summary that indexes legislative features of the various bills from "antitrust" to "tax deductibility of health insurance premiums for self-employed". Noticeably absent is a category relating to continuing medical education.

Does health system reform, therefore, have any major impact on CME? Undoubtedly the answer is yes, even if federal (and state) legislation remain silent on the issue.

The answer to this incongruity lies in the reform presently occurring in the marketplace that is proceeding at record pace without specific legislative mandate.

Physician practice arrangements are undergoing a revolution. Almost all practice groups are entering (or actively considering) alignments with an IPA, PHO, network or integrated community delivery system. Some practices have been purchased outright by hospitals or multispecialty clinics.

While the motivations for these changes are varied and complex, an overriding reason for these new arrangements is to put physicians and other providers into a position to compete for the health care business purchased by employers and government.

The current frenzy in this competition largely centers on cost. Providers are locked with each other in an effort to underbid competitors for contracts and referrals.

What has any of this to do with CME? The link is with quality of service. Cost containment may well drive these arrangements as long as consumers (patients) are satisfied with the quality of their health care. If they become dissatisfied with the quality offered within a given plan, they will soon demand better. The "Yugo" health plan will be noncompetitive.

To assure quality, health care organizations will require physicians and other health care professionals to provide contemporary care, with measurably good outcomes. Therefore, physicians will not only be encouraged but probably required to maintain and expand their skills through continuing education.

The "Yugo" health plan will be non-competitive.

Specialty recertification, objective demonstration of knowledge and skill and patient care outcomes that meet acceptable parameters may be the features of medical practice in the competitive era. Welcome to the brave new world of CME. IM



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Appointments are being accepted by calling 515/224-4639.

Mark was previously employed by the Iowa Medical Society as manager of specialty services.

The determination of the need for legal service and the choice of a lawyer are extremely important decisions and should not be based solely upon advertisements of self-proclaimed expertise. This disclosure is required by rule of the Supreme Court of Iowa.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Office Closed—Due to illness. Must sell furniture, equipment and supplies, including EKG and Doppler from Peripheral Vascular Studies, reception room, secretary's area, 3 exam rooms and physician's consultation room. Fine original prints (not reproductions) and other art pieces from office also available. Call 319/372-3083 for more information.

Emergency Medicine
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Immediate opportunity for primary care trained or experienced emergency physician. Trinity Regional Hospital is a 200-bed facility acting as a regional referral center for northwest Iowa. 15,000 annual volume/24-hour shifts. Medical backup is diverse with a full range of specialists represented. Ft. Dodge, a community of 26,000 nested in the beautiful Des Moines River valley, is the commercial hub of north central Iowa. Ft. Dodge provides a warm friendly community in which to live and raise a family. An outstanding compensation package includes health/dental, life, disability, malpractice insurances. Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

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Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.

Emergency Medicine
Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Estherville, Iowa—Well-established group of 5 family practitioners is recruiting a partner. Busy practice with the full range of services, including obstetrics and ER. Competitive financial package. Comfortable rural community of 7,000 people located minutes away from Spirit and Okoboji Lakes. Fabulous recreational opportunities available. Solid work force. Good schools. Low crime area. For more information, contact Christopher Kashnig, Physician Recruiter, PO Box 1100, Oshkosh, Wisconsin 54902. Call 414/236-2430, fax 414/236-1312.

(Continued next page)

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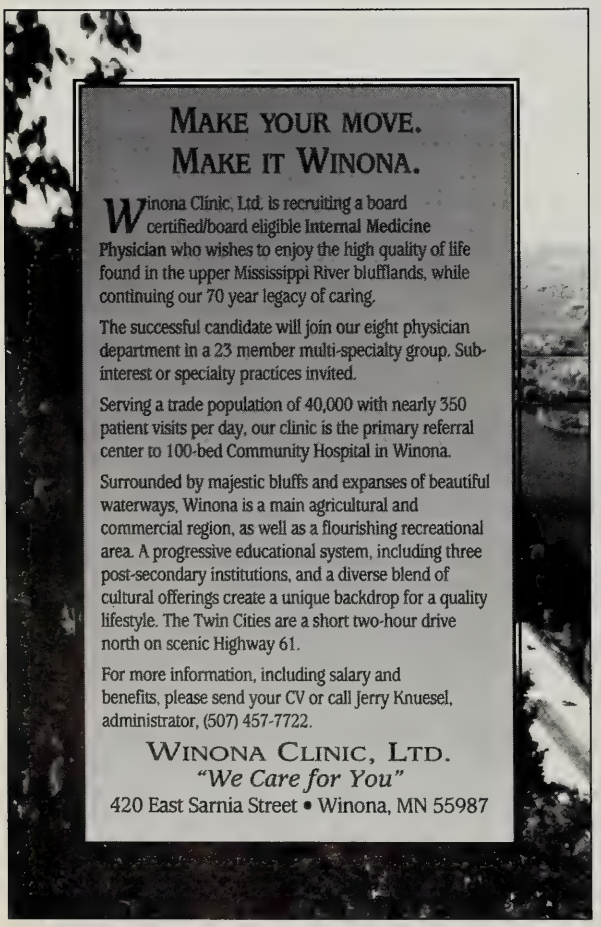
Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

General Faculty—The University of Iowa Department of Family Practice offers full-time faculty positions for residency-trained, ABFP certified family physicians. Obstetric skills and previous teaching experience highly desirable. Additional faculty needed to address new primary care initiatives. As a part of a full academic department, responsibilities include teaching, research and patient care. Well-established 24-resident program is university-administered, community-based and has admissions at community and university hospitals. A new model office facility is being built. Well-established department with special strengths in its clinical and behavioral science faculty. As a "Big Ten" university community, Iowa City is a great place to live. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are encouraged to apply. Submit a letter of interest and CV to Gerald J. Jogerst, MD, Interim Department Head, 2149 Steindler Building, Iowa City, Iowa 52242-1097; 319/335-8454.

General Surgeon, Dubuque, Iowa—BC/BE general surgeon needed. Join our well-established multispecialty clinic and enjoy referrals from 81 physician partners. Our clinic is physician owned and managed and we market our own HMO within a 45-mile radius of Dubuque. Our practice is located on the campus of a 330-bed hospital with a Level II trauma center and we have two university tertiary referral centers within 90 miles of Dubuque. Excellent income and benefits provide security and our community provides an exceptional lifestyle. Send CV to Denis Albright at Medical Associates Clinic, 1000 Langworthy, Dubuque, Iowa 52001 or call 800/648-6868.

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(Continued next page)

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Health system reform is very much alive

Health system reform is dead in Congress, but if you fall asleep you will awaken to a changed world. For example, Hospital Corporation of America merged with Columbia Healthcare Corporation and will operate 197 hospitals in 26 states. A recent transaction between Columbia/HCA and Health Trust Inc. will create an industry giant with an estimated $15 billion in annual revenue, 311 hospitals and 170,000 employees. Their strategy is "to attract more patients to bring down unit price, and use lower prices to attract still more patients." They hope to serve national companies with one-stop shopping and offer a full line of local services. No potential customer will need to look to a competing provider.

Columbia/HCA intends to purchase 30-40 hospitals a year for the next few years and encourage physicians to become stockholders in the hospital in their region. Their strategy is that, with the change to capitation, doctors and hospitals will profit only if they keep costs down.

Do you still want to bet capitation isn't coming? During the recent American Academy of Otolaryngology meeting, a California doctor warned us to say no to fee reductions because we will never recover. I can easily recall the time when physicians were in short supply in all specialities, medical schools were expanding, the armed forces were drafting physicians and research money was more readily available to attract physicians from the private sector. Now, the world has turned upside down. In most areas, physicians aren't negotiating from the strength of non-availability.

A recent *Wall Street Journal* editorial said many excuses have been given for the death of health reform but that the real reason is an American public which has been radically transformed by the first decades of the Information Age. To quote—"Top-down social engineering by Washington's central planners is now intuitively rejected as an anochromism and a hopelessly inefficient throwback to the bygone era of the Machine Age."

Central planning has been replaced by decentralized, horizontal networks where people stopped taking orders from bosses and started taking responsibility for results. I agree with the *Wall Street Journal* that "unmanaged competition and unmanaged adaptation yield bewildering, complex, yet enormously productive living systems." The changes we see coming in health care delivery will need local adaptability and input to survive.

The changes coming in health care delivery will need local adaptability and input to survive.

In late September, a group called Healthy Dubuque 2000 met to identify key community health issues. Task groups set goals and established implementation strategies.

I see the forces of health system reform emanating from the local level, rejecting the "central down" reformers that were defeated in Congress this year. Reform is very much alive and physicians should take an active role. IM



James White, MD

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IMS Update

BIG VICTORY FOR IMS, AMA

A Minnesota court judge has ruled that state's 2% tax on gross revenues of health care providers unconstitutional for physicians in neighboring states. Check this month's Medical Economics section, page 479, for more details about this successful IMS, AMA court challenge.

IMS dues statements

IMS dues statements went out in mid October. Iowa is unified at the state and county levels. Prompt payment of your dues will be greatly appreciated.

Iowa Medicine looks at domestic abuse

According to Robert McAfee, MD, AMA president, nearly all physicians have encountered victims of domestic violence in their practices — whether they know it or not.

The many facets of domestic abuse will be the focus of two special issues of *Iowa Medicine* in January and February, 1995.

The magazines will explore the complex problem with the goal of educating physicians on the best ways to help victims. The issues will contain articles on the psychological implications of domestic abuse, physicians' legal responsibilities, liability implications, the effects of domestic violence on children and information about the most effective ways to deal with batterers.

The IMS Task Force is also planning to produce a videotape and handbook designed to educate Iowa physicians.

Report on UI primary care initiatives

During 1994, 54% of the University of Iowa College of Medicine graduating class selected primary care residencies, Richard Nelson, MD, associate dean, told the IMS Executive Council at a recent meeting. Primary care includes family practice, internal medicine, pediatrics and obstetrics/gynecology. The 14-year average of UI medical school graduates who select primary care residencies is 53%, Dr. Nelson said.

Iowa residents account for 91% of students entering medical school in the UI's 1994 class; 50 of 157 1994 graduates (32%) entered family practice. For the period 1986-1994, the UI ranks first among medical schools graduating over 100 students in the number entering family practice.

1994-95 IMS directories mailed

You should have already received your new IMS Membership Directory. The directory contains a listing of IMS member physicians, a physician referral section and other pertinent information. If you have not received your directory, please call Sheryal Westbrook at IMS, 515/223-1401 or 800/747-3070. Extra copies of the directory are available to IMS members for $10.

SPECIALTY SOCIETY UPDATE

The Iowa Medical Group Management Association will sponsor a second Management Education Program for physicians and executive staff.

The American Medical Directors Association Iowa Chapter has elected Dr. Roy Overton II, Des Moines, as president. Dr. Clifford Rask of Maquoketa is vice president; Dr. Dean Bunting, Davenport, is secretary/treasurer.

The Third Party Reimbursement Committee of the Iowa Academy of Otolaryngology met recently to discuss RVU revisions by Blue Shield and other carriers. A meeting of the IAO membership is planned for this month in Iowa City.

The Iowa Vascular Surgery Society has elected 1995-96 officers including Anson Yeager, MD, president; John Klosak, MD, vice president; and Timothy Kresowik, MD, secretary-treasurer.

continued

AT A GLANCE

The updated Iowa Medical Society Articles of Incorporation and Bylaws *is available by calling Sandy Nelson at IMS headquarters.*

CADUCEUS Alcoholics Anonymous is available for physicians and their spouses. The group meets every Monday from 6:30 p.m. to 7:30 p.m. at 1313 High Street, Room 320, in Des Moines. According to Dr. Stan Haugland, the group's founder, there is no cost and no records are kept. For confidential inquiries, call 515/241-6021.

Physicians are also reminded that IMS sponsors an Assistance Program for Troubled Physicians (APTP). The APTP is a non-punitive, voluntary program through which physicians can seek treatment for substance abuse. For more information, contact Tina Preftakes at IMS headquarters, 515/223-1401 or 800/747-3070.

IMS Update

continued

Focus on IMS Alliance

The graying of America is a vivid reminder of our responsibilities in the field of elder care. In the land that worships youth, there are now 37,000 centenarians. By 2040, there will be 620,000.

A new human age — that of "super old" — is fast becoming reality. It remains to be seen whether tomorrow's elderly will be healthier than today's. All we know is their numbers and their needs are growing.

The IMS Alliance Health Promotions Committee has attempted to turn attention to the IMSA Med-Card program. This program involves distribution of wallet-sized prescription record cards specifically for the elderly. Distribution of these cards has increased dramatically since they were first made available through seven Area Agencies on Aging throughout Iowa.

Physicians are reminded that these cards are available for a cost of $4 per 100. Contact Bev Corron at IMS headquarters to order a supply. This is a wonderful service for your elderly patients.

Contributed by Barbara Bell, IMSA president

AMA studies major restructuring

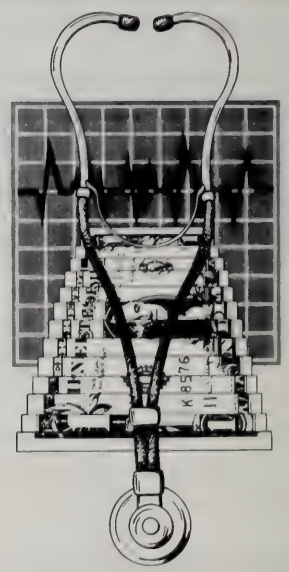
Under the headline "AMA writes prescription for change", the *Chicago Sun-Times* recently reported that the AMA is embarking on a major restructuring of its business operations. John Rhodes, Jr., MD of Pocahontas is one of those participating in the AMA's Consortium Study, which has been reported on previously in *Iowa Medicine*.

According to the *Sun-Times,* the AMA's intent is to restructure its business operations to concentrate on core services which make AMA the voice of the medical profession, a major resource of medical data research and to create new revenue sources that rely more on publishing and data-gathering and less on membership.

"We can't be all things to all people," commented AMA chairperson John Seward, MD in the article. "The restructuring will emphasize AMA's strengths — physician education, science, data-gathering and lobbying."

The group's deliberations are based on extensive research conducted during the summer. The Consortium's final recommendations will be made in late 1996. IM

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Health System Reform

Patient Protection Act important

Though health system reform is dead in this Congress, the AMA is urging physicians to continue efforts to educate legislators regarding provisions of the Patient Protection Act. As the private sector restructures health care delivery, the need for this important AMA initiative increases.

The Patient Protection Act would ensure that:

•patients and physicians control care, not insurance companies;

•patients have a choice of physicians and plans;

•patients have information about what their plan covers, copayments and prior approval requirements;

•physicians cannot be kicked out of a plan for giving patients the care they need.

For more information about the Patient Protection Act. contact Chris Clark at the IMS, 515/223-1401 or 800/747-3070.

Post-mortem on health system reform

In August, the U.S. House had all but abandoned efforts to pass a health care bill; in late September Senate Majority Leader George Mitchell announced that health system reform is dead for this year. There have been differing reactions and diverse opinions as to what went wrong — or didn't go wrong, depending on the viewpoint.

'Total obstructionism' of Republicans

Senate Majority Leader George Mitchell (D-Maine) blamed the "total obstructionism" of Republicans for the demise of health system reform in the 1994 Congress.

"The combination of the insurance industry on the outside and a majority of Republicans on the inside proved to be too much to overcome," Mitchell commented in the *Washington Post*.

Mitchell said he could not muster the 60 votes he needed to stop a promised filibuster to be led by Republicans on any of the Democrat-proposed health care bills.

Killing a bad bill

Senate Minority Leader Bob Dole (R-Kansas) and other Republicans claimed credit for killing what they believe was a bad bill and predicted the voters would thank them for it during the November elections.

"For all the right reasons, health care reform did not happen this year," said Senator Dole. "The American people wanted us to slow down".

Senator Phil Gramm (R-Texas) said America "rejoices that the president's health care plan is dead".

Dole says he's ready to tackle the issue again next year, but said the White House ought to let Congress submit legislation instead of producing "a gigantic package that people don't understand".

Dole and other Republicans expressed the hope that Congress will pass a scaled-down, bi-partisan bill in 1995.

'Journey is far from over'

In a prepared statement, President Clinton said the journey toward health system reform is "far, far from over".

"Some Republican leaders keep saying we should put this off until next year and I'm

continued

Worth Repeating

"Many participants in the health care reform fight, including the President's most loyal supporters on health care, said the issue died from the weight of many complicating factors: an overly bureaucratic plan, impaired presidential leadership, record campaign and media spending by opponents and rocky relations between the White House and Congress."

A *Washington Post* story entitled "Democrats pull the plug on health care reform".

AT A GLANCE

Dr. James White, IMS president, also discusses the lack of Congressional action on health system reform in his President Comments *column this month on page 471.*

Kansas senator Nancy Kassebaum got a call from a constituent who wanted to protest the whole notion of health care reform and what she called "socialized medicine". When the Senator asked the woman what health plan she depends on, she said "Medicare".

Health System Reform

continued

going to hold them to their word. We are going to keep up the fight against the interests who spent $300 million to stop health care reform."

Speaking at National Primary Care Day at the George Washington School of Medicine, Mrs. Clinton said the question of "who won the battle misses the point. Health care reform is not a boxing match, it's a journey."

In a story in the *New York Times*, Mrs. Clinton said the administration was "misunderstood" on health system reform and said the most frustrating failure was not getting Americans to understand the Clinton plan was "an opening offer".

At press time, the White House was reportedly preparing for Round II, with Mrs. Clinton remaining at the head of health reform efforts. The Administration has begun meeting with strong allies to strategize for 1995.

Among the basic questions reported being asked is whether the President's name should appear on any new plan.

Neither Republicans nor Democrats could find a consensus on another package.

Rounding up the usual suspects

Senator Charles Grassley (R-Iowa) said it is unclear whether health system reform "committed suicide or was shot" by special interests, Republicans and the Clinton administration itself.

"We're rounding up the usual suspects," he said.

Grassley said the President took too long to get his reform package together and too long to get it to Congress and did a poor job of selling it to the American people. Neither Republicans nor Democrats, he added, could find a consensus on another package.

Special interests may have also contributed, he said, but they were "legitimately aroused by the massive Clinton proposal that was much too ambitious and involved too much bureaucracy."

Middle class wasn't there

Senator Jay Rockefeller (D-W. Virginia) said the task of health system reform may have been too much too soon for a public mistrustful of government. "We might have been naive to think we could do it in two years," he said. "I'm not sure the middle class was there for us."

Charles Kahn of the Health Insurance Association of America said Congress "reflected the public in not being able to reach a consensus." Kahn said the HIAA, which sponsored the $14 million Harry and Louise ad campaign, said that group "played a role in informing the public of what was being considered."

"Most Americans are relatively satisfied with their health coverage and, in the end, preferred the status quo to a radical shift."

AMA reaction: don't blame, *learn*

The *New York Times* presented a full-page of reaction on the demise of health system reform, including remarks from John Seward, MD, AMA chair.

"The main reason health system reform didn't pass is simply the complexity of the nation's health care system and the complexity of the solutions proposed. Rather than blaming interest groups, the Administration or Congress, we have to learn from this exercise," Dr. Seward said. "We never thought it would be a simple job."

Dr. Seward added that the main question is whether comprehensive reform is still viable or whether reform should be incremental. He vowed that the AMA will "continue our commitment. The status quo is not appropriate."

Doing nothing could prove "fatal", warned James Todd, MD, executive vice president of the AMA.

"The vacuum created by Congress is going to be filled by an entrepreneurism that is more interested in profits than patients," he said. IM

Legislative Affairs

IMS legislative priorities

As was reported in the October *Iowa Medicine,* health system reform and CHMIS are among top IMS priorities for the 1995 session of the Iowa Legislature. Additional issues to be discussed at the November meeting of the IMS Committee on Legislation will be reported on next month. Priorities approved by the IMS Board include:

Review organ transplantation laws

During the 1994 legislative session, a proposal was initiated to modify Iowa's Anatomical Gift Act to change from a "required request" to a "designated donation" statute. This would be a major change in law which would affect patients, physicians and others in the health care community.

Consideration should be given to the fact that organ procurement and transplantation are concerns nationwide and coordination among states is critical. IMS has made a commitment to work with other organizations to review laws and consider recommendations for change.

LEGISLATIVE VIDEOTAPE AVAILABLE

A videotape presentation is available to Iowa physicians who want information on the Iowa Medical Society's priorities for the 1995 session of the Iowa Legislature. The tape is about 20 minutes long. The tape reviews IMS legislative priorities and discusses the impact of grass roots involvement in the political process.

As scheduling permits, Paul Bishop, IMS legislative liaison, will be on hand to answer questions after the tape is shown. The videotape would make a good program for county medical societies or specialty societies.

To arrange for a legislative briefing in your area, call Becky Roorda or Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

SCOPE OF PRACTICE ISSUES

Many issues relating to expansion of the scope of practice of limited health care practitioners are being discussed this year.

Health reform efforts have provided a new forum for these issues in addition to the traditional approach of lobbying legislators for expanded services allowed under a practice act. Issues which may be debated include:

Pharmacist prescribing of "legend" drugs

The IMS believes that allowing pharmacists to prescribe drugs is not to the benefit of patients. While pharmacists play an important role as part of the health care team, they should not be granted authority to prescribe drugs because they are not trained in diagnosis and treatment of illnesses.

OTHER ISSUES

Self-referral restrictions

In 1993, legislation was discussed in the Iowa Senate to place restrictions on physician ownership and investment in certain health care facilities.

The IMS opposed this legislation for several reasons including the fact we are unaware of a problem with self-referral in Iowa. Similar legislation wa narrowly defeated as an amendment to SF 2222 in 1994.

Limit copying charges for medical records

In 1993, legislation was discussed to limit the amount physicians and hospitals can charge for copies of medical records.

The IMS and the Iowa State Bar Association have both approved *Principles of Cooperation for Attorneys and Physicians* which provide guidelines on charges.

The IMS believes use of such guidelines by physicians and attorneys is preferable to addressing the issue in state law. However, the issue may be discussed again in 1995.

Child support payment as condition of licensure

Proposals have been advanced to help

continued

AT A GLANCE

At a recent meeting of the Iowa Telemedicine Advisory Council, it was reported that Iowa has received approximately 40% of the available federal telemedicine funds. Future grant proposals will likely focus on research aspects rather than purchase of equipment.

Iowa Governor Terry Branstad has a number of state health system reform initiatives on his priority list in 1995. They include premium credits for working low-income Iowans, medical liability reform, full insurance deductibility for health insurance purchased by self-employed Iowans and medical savings accounts. The Governor says these measures will allow Iowa to continue on the forefront of health reform.

Legislative Affairs

continued

enforce child support payment agreements through the professional licensure process — a professional license could not be granted unless the applicant was current on child support payments.

While the IMS supports efforts to enforce child support agreements, the traditional IMS position has been that a license to practice should be granted on the basis of professional competence and not as a mechanism to enforce other laws or influence social policies.

APPROPRIATIONS

Board of Medical Examiners

The IMS believes the Board of Medical Examiners should be fully funded through the appropriations process. Iowa law requires that physician license fees be set at a level to fund the operations of the Board. The IMS believes revenue collected through this mechanism should be appropriated to the Board.

Medicaid cost containment

Medicaid cost containment has been a major legislative issue for the last few years. Because of concerns about the growing Medicaid budget, legislators have mandated such cost containment meaures as managed care plans and requiring prior authorization for certain prescription drugs.

Even though the budget situation has improved for the current fiscal year, cost containment measures may be discussed, particularly in the area of prescription drug costs.

Family Practice Residency Program

The IMS supports funding for the Statewide Family Practice Residency Program. This program is essential for ensuring availability of family physicians to practice in both rural and urban areas.

State medical examiner

The IMS supports funding for the state medical examiner through the Department of Public Safety. Iowa's medical examiner system plays an essential role in public safety. Support and assistance for the state and county examiners will help ensure the system functions properly. IM

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Medical Economics

IMS, AMA tax challenge is successful

Iowa physicians won a major battle in Minnesota courts when a district court judge ruled against a plan to collect a 2% tax on non-Minnesota health care providers.

The AMA — on behalf of physician plaintiffs in Iowa, Wisconsin, North Dakota and South Dakota — had filed a lawsuit challenging the constitutionality of the Minnesota Care tax on out-of-state providers.

The law at issue — effective January 1, 1994 — imposed tax liability on any non-resident health care provider who treated 20 or more patients living in Minnesota in a calendar year. The suit argued that the Minnesota statute enacted in 1992 violated the commerce and due process clauses of the constitution.

The court agreed, and District Court Judge Michael Monahan ruled that the due process and commerce clauses prevent a state from taxing people, property or transactions that do not have adequate link with the taxing state. The ruling also pointed out that the language of the act would have applied to physicians all over America who treat patients from Minnesota.

"The hapless health care provider in California, Arizona or Florida who treats a bus-load of Minnesota tourists could find the Minnesota commissioner of revenue at its door," read the ruling.

The ruling prohibits the state of Minnesota from imposing the tax on the plaintiff physicians or on any non-Minnesota physician.

At a recent meeting of the IMS Executive Council, an AMA representative called the Minnesota decision to tax out-of-state providers "a fit of lunacy" and warned there could be an appeal of the ruling.

Eldon Huston, executive vice president of the Iowa Medical Society, called the favorable ruling "an example of what can be accomplished when organized medicine at all levels works together for the good of physicians."

Iowa hospitals, in cooperation with hospitals from Wisconsin and North and South Dakota, have also challenged the constitutionality of the Minnesota provider tax. As of press time, this challenge was pending before District Judge Monahan.

CHMIS is coming July 1, 1996

The Community Health Management Information System (CHMIS), signed into law in April of this year, will be phased in starting July 1, 1996.

This means that on this date, all physicians and hospitals must submit claims electronically.

What is CHMIS?

The CHMIS concept was designed by the Hartford Foundation to meet the needs of all users in the system and improve the efficiency of processing provider-patient encounters. All health care data provided by claims submitted is stored in a central data repository. Access to the data is granted to various stake holders.

Who will govern CHMIS?

The Governor has appointed a governing board to oversee all decisions made in implementation of CHMIS. The board is comprised of two physicians, two hospitals, two insurers and six consumers. Dale Andringa, MD, Des Moines; and Beth Bruening, MD, Sioux City, are the physician representatives appointed by the Governor.

Committees

The following committees will work under the direction of the governing board. The physician and clinic manager members recommended by the IMS and approved by the governing board are:

•**Quality Review Advisory Committee** — William Langley, MD; Elie Saikaly, MD.

•**Ethics and Confidentiality Advisory Committee** — Charles Jons, MD; Ed Maahs.

•**Data Advisory Committee** — William

continued

AT A GLANCE

Polk County District Judge Arthur Gamble has promised a speedy ruling in a lawsuit that has delayed a new mental health program for Medicaid recipients. After months of competition, the Department of Human Services last June awarded the contract to Value Behavioral Health, Inc. The runner-up bidder — Medco — sued DHS to stop the contract. James Carney, Medco's Des Moines attorney, said the flaw in the DHS bidding process arises from a corporate connection between Value Behavioral Health and another firm helping the DHS develop the psychiatric care management plan.

The U.S. Department of Labor has completed its Occupational Safety and Health Hazards in Agriculture: A Review of the Literature. *Iowa information is available through the Iowa Department of Public Health.*

Medical Economics

continued

Bonney, MD; John Brinkman, MD; Amy Wehr.

•**Communications and Education** — Laine Dvorak, MD; Thomas Evans, MD.

•**Technical Advisory Committee** — Thomas Menzel, MD; Mark Purtle, MD; Julie Drews.

IMS CHMIS activity

The IMS has its own CHMIS committee which plans to meet frequently with the physician members of the state CHMIS committees. The best ways to help IMS member physicians prepare for the July 1, 1996 implementation date are being discussed. The IMS CHMIS Committee is currently seeking a qualified vendor or network to assist physicians with CHMIS implementation.

The IMS will be scheduling local meetings around Iowa to provide up-to-date training on CHMIS. Call Donna Bottorff at 800/747-3070 or 515/223-1401 with questions about CHMIS.

CLIA hotline dropped

As of September 30, HCFA terminated the CLIA hotline number. Physicians seeking information regarding CLIA certification, fees, inspections, etc. after that date should contact Nancy Ruzicka in the Inspections and Appeals office, 515/281-4120 or the state inspector in Iowa City, 319/335-4500.

Correct coding for Medicaid EPSDT

Under OBRA '89 legislation, states are required to demonstrate that 80% of Medicaid recipients under age 21 are receiving Early Periodic Screening, Diagnosis and Treatment (EPSDT) screens according to the American Academy of Pediatrics schedule. The goal is 80% screens by 1995.

Iowa's rate is increasing, but further significant progress is required to reach the goal.

Previously, HCFA has not allowed services billed as well-child CPT codes to be used in meeting the 80% goal since use of these codes has not assured that the components of an EPSDT screen have been provided. As Iowa's overall Medicaid funding will be jeopardized if the goal is not attained, a policy change has been proposed — in order to use any of the following well-child (preventive office visit) CPT codes, physicians will be required to provide all components of an EPSDT screen:

99381	99382	99383	99384	99385
99391	99392	99393	99394	99395

Iowa physicians and data collection: IS YOUR OFFICE READY?

This issue of *Iowa Medicine* contains the second of three special inserts on why physicians must become knowledgeable and involved in data collection systems such as the Health Employer Data Information Set (HEDIS).

This month's insert compares HEDIS, the Community Health Management Information System (CHMIS) and other important data collection efforts. The December insert will discuss ways every Iowa physician can participate and become a leader in this field.

Until the proposed rule change is finalized (approximately February 1, 1995) it is recommended physicians begin providing all components of an EPSDT screen when providing preventive care. Effective October 1, 1994, if these codes are billed with an appropriate modifier, they will pay at the EPSDT rate of $41.88 (ages 0-17) or $40.23 (ages 18-20), which is higher than the current well-child reimbursement. If the well-child code is not accompanied by an EPSDT modifier, reimbursement will remain at the current well-child code reimbursement level of $21.57 (new) or $19.73 (established).

AMA reacts to inflammatory comments

Nationally-syndicated writer Charley Reese recently called for "doctor control" and said malpractice "claims 80,000 lives a year". Many physicians wrote letters asking for an apology and the AMA began to trail the false statistic quoted by Reese. As a result, this month *Medical Economics* will run an article refuting the statement. In the article, authors of the **Harvard Study on Medical Malpractice** are interviewed.

The faulty statistic quoted by Reese came from the *New York Times*, which cited the statistic without verifying it. IM

Practice Management

Important E & M coding seminars

HCFA's E & M coding documentation guidelines have been released. During 1995, HCFA will begin using these guidelines in post-payment audits of physician records.

IMS is offering a seminar which reviews appropriate selection and documentation. Information on Iowa's utilization patterns compared with national patterns will be provided. Actual chart documentation case studies and data reports will be presented.

Since the focus is on code selection, the workshop is for physicians; staff are welcome to attend with their physician employer.

The seminar schedule appears in the box below. The cost of the seminar is $50 for IMS members or staff; $75 for nonmembers or staff. For more information or to register, call Barbara Heck or Sherry Johnson at IMS headquarters, 515/223-1401 or 800/747-3070.

Reducing Workers' Comp claims

In 1991, IMS endorsed a Workers' Compensation Safety program offered by Farm Bureau. The program focuses on reducing claims and insurance costs for participating IMS members. For information on this program, call Larry Eaton of Farm Bureau, 515/226-6270. Look on page 485 of this issue for an article on Iowa's Workers' Compensation System. IM

Midwest Medical Insurance Company Focus on Risk Management

What do today's customers — patients — want? Patient surveys tell us they want information about their problem and evidence their physician really cares.

Good patient relations begin the moment a person contacts a physician or clinic. Good communication skills, rapport and patient relation policies are among the most effective ways to prevent malpractice claims:

- Give patients a brochure explaining clinic services and policies.
- Emphasize office staff's role in promoting good patient relations.
- Involve patients in decisions through information, be sensitive to the patient's knowledge level and avoid medical jargon.
- Communicate appointment delays to patients and offer the option of waiting or rescheduling.
- Inform patients when telephone calls are likely to be returned.

Patients who feel they have a good relationship with their physician are less likely to turn to an attorney when treatment results are less than optimal.

For more information contact Lori Atkinson, MMIC risk management coordinator, Midwest Medical Insurance Company, PO Box 65790, West Des Moines, Iowa 50265, 800/798-9870 or 515/223-1482.

AT A GLANCE

Participants in the Statewide Physician Group Health Plan should have received their renewal notices by now. Renewals are due by November 21 to Bernie Lowe Associates. If you did not receive your notice, contact Bernie Lowe Associates at 515/222-0811.

Medical Assistants Week was October 17-21. The Iowa Society of Medical Assistants is a professional organization for medical office personnel. If you would like more information on this organization, call Diane Marshall, 515/243-8676 or 515/961-7164.

Practice Management Workshops for You

CPT Coding	**Nov. 15**	**Davenport**
ICD-9 Coding	**Nov. 17**	**Davenport**
CLIA Update	**Nov. 30**	**W. Des Moines**
Quality in Medical Office	**Dec. 6**	**Davenport**
Anatomy & Physiology	**Dec. 7**	**W. Des Moines**

E & M Coding

Nov. 2	**Cedar Rapids**	**Nov. 16**	**Sioux City**
Nov. 3	**Des Moines**	**Nov. 17**	**Mason City**
Nov. 9	**Davenport**		

For more information on any IMS practice management seminar, call Mary Reinsmoen or Sherry Johnson at the Iowa Medical Society, 515/223-1401 or 800/747-3070.

Newsmakers

AT A GLANCE

More than 300 Des Moines area physicians are partners with Mercy Hospital Medical Center in the state's first accountable health plan called SecureCare of Iowa. The health plan is owned 50% by the physicians and 50% by the hospital, according to Donald Burrows, MD, chairman of SecureCare of Iowa.

Five Sioux Falls, South Dakota clinics and a Canton, South Dakota clinic are joining Sioux Valley Hospital in a health care alliance tentatively called Sioux Valley Health Alliance.

Response to IMS president's comments

Letter to the Editor

Dear Dr. White:

I wanted to respond to your comments and "strategies" for the future in the September 1994 issue of *Iowa Medicine.* Although I agree with much of your perspective, I feel it is important that Iowa physicians be aware of the strategies that occurred in the Dubuque area over the past two decades and to perhaps correct a misconception that you presented in your comments.

In the mid-seventies, shortly after I began practicing, a major Iowa insurance carrier proposed a pilot program to Medical Associates to develop a managed care product. Medical Associates elected at that time not to pursue that offer, but follow the development of HMOs in Iowa, as well as nationally, through the American Group Practice Assoication's regional and annual national programs.

In 1980, the Dubuque County Medical Society was approached by John Deere to develop an interest by local physicians in forming an IPA similar to that of John Deere in the Quad Cities. After bipartisan representation and two years of looking at active HMOs, the Dubuque County Medical Society voted not to participate in an IPA.

At that time, Medical Associates made a decision to fund its own feasibility study for the viability of an HMO. Local business support was offered for the concept. The formation of the HMO, staffing and funding of insurance reserves was accomplished solely by the physicians of Medical Associates, as well as attainment of the federal qualification. At that time, federal qualification was an important requirement by a business as a seal of approval. At no time did Medical Associates receive local or federal "grant money" in the development of our managed care system as you alluded to in your article.

We, as you pointed out, came to appreciate the concept of being "at risk." After rapid growth to 50,000 enrollees, Medical Associates and its HMO retrenched, thrived and are now positioned to participate in and meet the challenge of future health care systems through the option of the managed care and fee-for-service group.

The current medical environment undoubtedly requires all physicians to be adaptable and active participants in meeting physicians' and patients' needs for a quality health care system.

Thanks for the opportunity to respond to your comments. *—Ross Madden, MD, medical director, Medical Associates Clinic, Dubuque.*

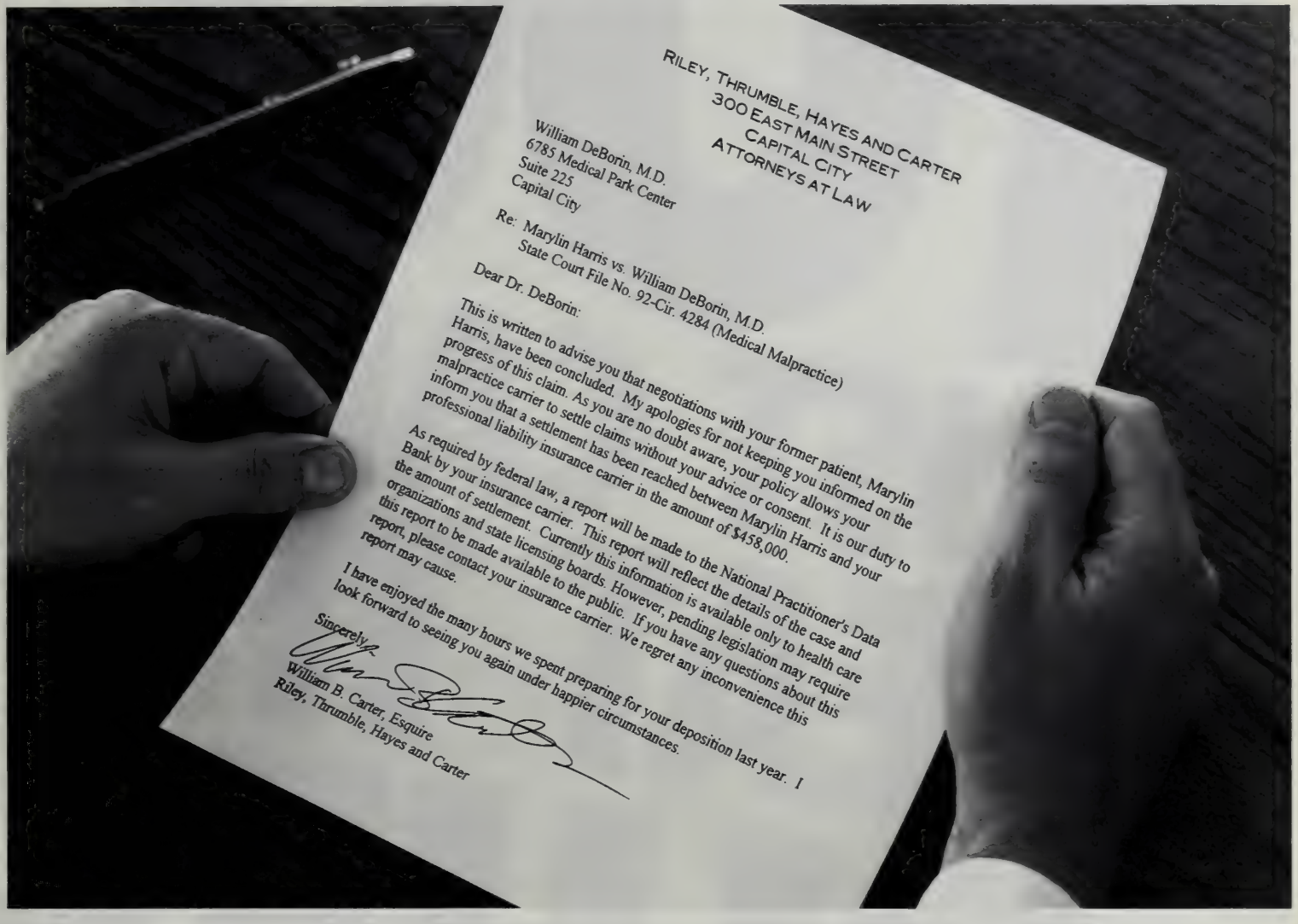
Awards, appointments, etc.

Dr. Eugene Cherney, a Des Moines plastic surgeon, has been elected president of Iowa Physicians for Life. **Dr. Nidal Harb,** cardiologist at Medical Associates in Clinton, has been nominated to serve on the State Board of Directors for the American Heart Association for an additional two years. **Dr. Christopher Blodi,** West Des Moines ophthalmologist, has received the American Academy of Ophthalmology Honor Award. **Dr. Grant Westenfelder,** internal medicine, has joined Medical Associates Clinic in Dubuque. **Dr. John Redwine,** family practice, has been elected to the Sioux City public school board. **Dr. Kevin Campbell,** UI College of Medicine professor of physiology and biophysics and Howard Hughes Medical Institute investigator, received the American Society for Biochemistry and Molecular Biology-Amgen Scientific Achievement Award.

Deceased members

John Keith, MD, 87, life member, general practice, Cedar Rapids, died May 25 IM

Medical Protective Policyowners *NEVER* get letters like this!



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300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

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Iowa's Workers' Compensation System

The cost of workers' compensation to employers is frequently cited as one of the most important factors in measuring a state's business climate. Iowa continues to be recognized as a low cost state for workers' compensation purposes.

Iowa's workers' compensation laws, administered by the Department of Employment Services (DES), provide medical, indemnity (cash) and vocational rehabilitation benefits to employees who have sustained injuries arising out of and in the course of their employment.

When death results from the injury, compensation is payable to the employee's dependents and the employer is responsible for reasonable burial expenses not to exceed $5,000. Generally, benefits are payable regardless of fault and are the exclusive remedy of the employee against the employer. The DES is also responsible for adjudicating disputes arising under Iowa's Second Injury Compensation Act.

Iowa continues to be recognized as a low cost state.

The cost of indemnity benefits per 100,000 workers, the cost of medical benefits per 100,000 workers, total cost (indemnity plus medical) of benefits per 100,000 workers, the benefit cost rate and the cost of permanent partial disability benefits per 100,000 workers are important measurements of workers' compensation costs to employers. Iowa fairs very well in each of these categories (see box next page).

Some states that have achieved a low cost status in workers' compensation have done so by paying inadequate benefits to injured workers and/or resorting to unduly restrictive definitions of compensable injury. Such is not the case in Iowa. Iowa's Workers' Compensation System has achieved a low cost status without resorting to either inadequate weekly rates or restrictive definitions.

The maximum weekly rate payable under Iowa's workers' compensation law is the highest in the nation, both in terms of dollars and as a percentage of the statewide average weekly wage. In addition to the workers' compensation law providing adequate and equitable benefits to injured workers and their dependents, the term "injury" under the workers' compensation law has been defined very broadly by the Iowa Supreme Court.

The DES has implemented several new procedures to improve services:

- Claims analysts, rather than a deputy industrial commissioner, now review requests for approval of settlements and commutations. As a result, time to review and approve settlements/commutations has been reduced to under three days and the deputy previously devoted to settlements is now able to hear and decide more contested cases.
- The DES mediation program has proven to be a popular and cost effective vehicle for resolving disputes and the program has been expanded twice.

continued

Byron Orton
Mr. Orton is Iowa's industrial commissioner, the administrator of the Department of Employment Services Divison of Industrial Services.

Guest Article

continued

• Disputes by injured workers petitioning the industrial commissioner for alternate medical care are heard and decided not more than 14 calendar days after the petition is filed.

• Telephone conference hearings are now available in the alternate medical care and expedited hearing procedures.

• The DES has printed *A Guide to Workers' Compensation*. We believe the guide will be useful to employers, employees, labor unions, insurance carriers and others who have an interest in Iowa's Workers' Compensation System.

• Workers' compensation decisions are now available through the DES data center.

• On a quarterly basis, the DES produces instructional and informative videotapes covering a variety of workers' compensation issues.

If you have questions concerning your rights and responsibilities under the workers' compensation laws, please contact the Division of Industrial Services at 515/281-5934 or 1-800/JOB-IOWA. IM

For more information about workers' compensation in Iowa call 1/800-JOB-IOWA.

Costs of Workers' Compensation (*per 100,000 workers)

- **Cost of Indemnity Benefits***
  The cost to Iowa's employers is 52.9% of the national average with only seven jurisdictions having lower indemnity costs.
- **Cost of Medical Benefits***
  The cost to Iowa's employers is 62.8% of the national average with only four jurisdictions having lower medical costs.
- **Total Cost (Indemnity plus Medical) of Benefits***
  Total cost to Iowa's employers is 56.9% of the national average with only four jurisdictions having lower total costs.
- **Benefit Cost Rate**
  For the entire country, $1.79 in benefits was paid out for every $100 of payroll. In Iowa $1.06 in benefits was paid out for every $100 of payroll, putting costs in Iowa at 59.2% of the national average. Iowa ranks 47th lowest of the 51 jurisdictions in terms of benefit costs per $100 of payroll.
- **Cost of permanent partial disability benefits***
  Compared to the national averages, the frequency of permanent partial disability cases in Iowa (571) is 84.5%; the average cost in Iowa ($17,058) is 55.5%; the total cost of permanent partial disability benefits in Iowa ($9.74M) is 49.7%. Iowa is one of seven states that has average frequencies and costs below the national averages and as a result has total costs per 100,000 workers that are less than half of the national average.

These statistics were taken from *John Burton's Workers' Compensation Monitor* (July/August 1993) and *Ed Welch On Workers' Compensation* (March 1994).

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DOCTOR, IS YOUR PRACTICE MANAGER HERE?



If your manager is not in attendance, you need to know about the Iowa Medical Group Management Association (IMGMA). It's an organization that promotes and upholds high standards of medical management. And, through its membership, IMGMA represents nearly 80% of Iowa's active physicians.

IMGMA is a source of valuable information—through spring and fall education programs, quarterly newsletters, salary surveys, etc.

Encourage your management staff to become active within the IMGMA membership. For membership information contact:

IOWA MEDICIAL GROUP MANAGEMENT ASSOCIATION
1001 Grand Avenue, West Des Moines, IA 50265
Phone: 515/223-2816 or toll-free 1/800-728-5398

FUTURES

Finding the best consultant

NOTE: This article was written by Thomas Gorey, JD, president of Policy Planning Associates, a health care consulting firm in Crystal Lake, Illinois. Mr. Gorey was a guest speaker at the Iowa Medical Society's October 27 Des Moines conference "Organizing for Change".

What is a consultant?

A consultant is anyone who provides professional or expert advice to another for a fee, typically to multiple clients.

With the rapid changes taking place in medical practice, an increasing number of physicians are turning to consultants for assistance in designing and implementing successful practice development strategies.

If ever a profession defied description, it is that of "consultant". Generally, a consultant is anyone who provides professional or expert advice to another for a fee. Typically, a consultant provides services to multiple clients.

Unfortunately, the perception of the consulting field is imprecise. "Consultant" can mean the professional who works for an international management consulting firm with thousands of employees to someone who is between jobs and working out of his home.

What do consultants do?

The range of services provided by consultants is extremely broad. Among the many services commonly provided by consultants to physicians are: practice management, strategic planning and marketing, practice mergers, managed care contracting, physician organization developments, practice valuation and information systems development.

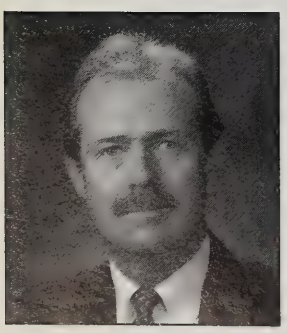
Why retain a consultant?

Perhaps the most obvious situation is when the physician has a specific problem that needs to be addressed. For example, a physician may have experienced a recent decline in patient revenue and wants expert advice in diagnosing the problem and implementing corrective measures. Or, a physician may want assistance in implementing a communications and marketing program. In some cases, there may be no apparent problem with a practice, but a physician may simply want a practice "audit" to determine whether steps can be taken to strengthen the practice and avoid future problems.

In today's competitive environment, physicians' consulting needs are more complex. Issues involving practice mergers, formation of physician organizations and managed care contracting typically require a different type of consulting expertise.

Identifying the consultant

How should a physician find a qualified consultant? The first step is to clearly identify your objectives. Unless the physician can succinctly communicate what they want to accomplish, it is unlikely the consultant will be able to develop a proposal or a strategy that is fully responsive. Finding a consultant can be challenging, but the process is not unlike



THOMAS GOREY, JD
Mr. Gorey is president of Policy Planning Associates, a health care consulting firm in Crystal Lake, Illinois. He was formerly on the staff of the American Medical Association.

HEALTH CARE DATA COLLECTION

by Timothy Pella & William Bonney, MD ***2nd*** *in a series*

Health services Research (HSR) involves physicians and social scientists. Goals include detection of long-range health trends, comparison of treatments and results (outcomes) for each diagnosis and guidance of health system reform.

HSR is also asked to evaluate the quality of health care and the performance of health plans or physicians. These requests come from employers, insurance companies, health plans and governmental agencies which have traditionally used claims data and cost.

For a health care data system, ideal design involves the following steps: 1) decide which questions to ask; 2) determine the data needed to answer those questions; 3) decide how to analyze the data; 4) identify the sources of data; 5) design a database; 6) collect the data. This approach requires HSR participation from the start.

Measurement issues in quality and outcomes

- Patient characteristics—The patient is a factor in the outcome of health care delivery. (For example, genetic propensity to illness, environment and compliance with treatment plans.)
- Severity and risk of illness—To compare patient populations for outcomes of health care, we must adjust for risk of illness when the patients enroll in health plans. To compare health care organizations for the cost and quality of acute care, we must adjust the enrolled patients for severity of illness when the care is delivered. These adjustments involve the All Patient Refined DRGs (APR-DRGs), MedisGroups and other software or statistical procedures.
- Longitudinal study and disease prevention—The data needed for health system reform includes longitudinal study of lifetime health and treatment outcomes in large populations. HEDIS 2.0 specifies repeated data collection on a few selected measures of chronic illness, childbirth outcomes and immunizations. However, each data collection involves only the current enrollment, not all previous patients.
- Attribution—It is always a challenge to prove cause and effect for every health change detected.
- Functional health status—Standard Form 36 (SF36) is a patient questionnaire developed by the Rand Corporation for the National Health Insurance Data project.
- Patient satisfaction—There are numerous patient questionnaires to assess satisfaction with health plans and services.

HCFA

Since Medicare/Medicaid began 25 years ago the Health Care Financing Administration (HCFA) has pursued its own unique program for medicare claims data collection, a congressional mandate. Data sources are claim forms; the HCFA-1500 is used by physician offices and the UB-92 is filed by hospitals.

The data have been witheld from most potential users because of confidentiality restrictions.

Quality of care relates to whether physician services, procedures and level of care are appropriate to diagnosis (Diagnostic Related Group, DRG) under HCFA guidelines. Med Profile, an expanded version of UB-92, includes longitudinal outpatient follow-up data such as hospital readmission and mortality and therefore can support outcomes research.

Recently HCFA began the Health Care Quality Improvement Program (HCQIP) to detect hospital-specific variations from regional practice standards and

Is your office ready?

The October insert, the first in a series of three, introduced health care data collection. This insert compares HEDIS, Iowa CHMIS and other plans already active in your community.

As you read this information, please refer to the glossary of terms in the first insert.

HEDIS 2.0

The Health Plan Employer Data and Information Set (HEDIS) arose from efforts of the HMO Group, four large employers, Towers Perrin and Kaiser Permanente starting in 1989. The objectives were to understand employer needs to document the "value" of a health plan and the care delivered to its members and to develop performance measures to quantify that "value."

The result was a standardized set of definitions and specifications to measure health plan performance and quality of health care for private health plan enrollees, with potential for longitudinal study (repeated data collection).

For quality of care, selected performance measures are preventive care (immunization, cholesterol screening, mamography, Pap test); maternal care (prenatal care, birthweight studies); acute and chronic care (admissions of asthma, diabetic and retinal care) and mental health (ambulatory care after hospitalization).

Other measures include percent of members that use the health plan, annual per capita cost, board certification rates among primary care physicians and a survey to determine the health plan information desired by potential patients.

After trial and review, HEDIS 1.0 was turned over to the National Committee for Quality Assurance (NCQA), a private, nonprofit corporation, for revision and refinement.

To confirm data reliability, NCQA began the National Report Card Project, a review of primary medical records by health plans that have used HEDIS. Participants include BCBS of Iowa and South Dakota (IASD). The project considers only 15 performance measures (compared to 60 in HEDIS 2.0).

One goal is to develop and validate performance measures to compare health plans. This includes patient satisfaction. NCQA will accept patient survey data in any format but recommends the Group Health Association of America (GHAA) form or the Employee Health Care Value Survey used by several large employers.

HEDIS 2.0, released in 1993, has found widespread application and may become the national standard for comparison of health care plans. Health plans are now asked by employers and private insurers to provide information in the HEDIS 2.0 format. It remains under continuous revision and open to further improvements.

IASD

Blue Cross and Blue Shield of Iowa and South Dakota (IASD) offers data collection and analysis to employers, health plans and other customers. In collaboration with another private corporation it is also developing an electronic claims processing capability.

Its extensive data bank includes Medicare claims data from HCFA-1500 and UB-92.

To analyze quality of care and practice variations it uses HEDIS 2.0 standards. With Value Profiler (VP), Iowa patterns of care are compared to practice guidelines developed by expert panels. In software now under development with Harvard School of Public Health, Iowa patterns of care undergo small area analysis with individual physicians compared to all Iowa physicians.

In regard to performance indicators, this data set can compare physicians, HMOs or larger health plans. End results include confidential reports to physicians for their personal evaluation.

Adjustment for severity and risk of illness is made with Patient Management Categories (PMC) and Ambulatory Care Groups (ACG).

For patient satisfaction analysis, every visit is followed by a questionnaire to patients in the Blue Advantage Network, a private BCBS insurance plan.

IASD participates in the NCQA National Report Card Project and uses HEDIS 2.0 criteria to survey subscribers in its own Alliance Select PPO as well as other private health plans. These data describe only the employed population.

Shortcomings of data systems

With the exception of CHMIS, data collection systems generally address the proprietary concerns of their organizers and are not necessarily designed for universal application.

For example, with a few exceptions such as IMS and Qualitrac, the data does not contain the longitudinal measures of outcomes needed for properly guided health system reform. For example, except for the systems based on HEDIS 2.0, none is interactive with other systems.

Universal compatibility depends on universal data standards. Without such standards the validity of any analysis (e.g. to compare the performance of health plans) would be suspect if the data came from multiple sources.

In the December issue of Iowa Medicine, *look for the final insert in this series. Find out what opportunities Iowa physicians have to participate in the development of data collection.*

that which you would use to select any other professional.

Colleagues — Perhaps the most common way of identifying a consultant is through word-of-mouth. Ask your colleagues whether they have used a consultant, who they used, what services were provided and whether they were satisfied with the results.

Professional associations — Some state and specialty medical societies have programs to assist their members in identifying qualified consultants. Such assistance can range from publishing a listing or directory of consultants to operation of a consultant referral network to providing or brokering such services.

Other associations — A number of other associations can assist in identifying consultants. For example, the Medical Group Management Association offers consulting services. There are also several national associations whose members consist of professional consultants, including the Society of Medical-Dental Management Consultants in Kansas City, Missouri and the Institute of Certified Professional Business Consultants in Chicago. The National Health Lawyers Association in Washington, DC and the Health Law Section of the American Bar Association in Chicago represent possible sources of information on the many attorneys with heath law practices.

Professional journals — Many consultants write articles for publication in medical journals, health care newsletters and other publications. Perusing medical publications — particularly those that are practice-oriented rather than clinically-oriented — can be helpful in generating a list of consultants and gaining insight into the consultant's knowledge. Consultants also speak at professional meetings and workshops. If you hear a consultant who impresses you, that speaker may be a candidate for your project.

If you hear a consultant at a workshop who impresses you, that consultant may be a candidate for your project.

Selecting the consultant

Narrowing the search to the consultant who is right for you can be difficult and time-consuming. A number of factors are important.

Qualifications and expertise — A critical step in evaluating potential consultants is determining whether they have the qualifications and expertise required to meet your needs. For example, if you are interested in merging your solo practice with two other solo practices, seek a consultant who has specific expertise in practice mergers. Other criteria that can help narrow the field include: number of years in practice and number of clients served, educational training, certification and experience working with physicians in your specialty. Consultants also should be able to provide you with at least three references (preferably physicians) from previous engagements.

Ask the referring physicians the following questions:

- Were they pleased with the consultant's performance?
- What were the consultant's strengths and weaknesses?
- Was the project completed in a timely manner?
- Was the consultant accessible throughout the project? (For example, were phone calls

returned promptly?)

•Were there any aspects of the consultant's work with which they were dissatisfied?

•Would they use the consultant again?

Availability — The individuals who have the most expertise and whom you would most like to retain are likely to be the busiest. A major source of disappointment for many clients is signing a consulting agreement based on contacts with a firm's senior consultant, only to find that junior members of the firm are assigned the bulk of the work. To avoid surprises, it's important to discuss the names and qualifications of all consultants who will be involved in your project and the role each will play. Get this in writing, if possible.

Location of the firm — Theoretically, it may be desirable to work with a firm located nearby. In practice, geographic location is relatively insignificant. There are firms that have a focus in a particular state or region but most firms are available to provide services on a national basis. The following issues are much more important than location:

•Does the firm have a grasp of the medical practice environment in this state and an understanding of the unique forces at stake?

•Will the location of the firm make it difficult to arrange meetings?

•Will travel expenses add significantly to the cost?

•Will travel time be billed?

Size and orientation of firm — The consulting field has a range of practice arrangements. Some firms specialize in particular types of projects while others provide a full spectrum of services designed to meet most practice-related issues that arise in medical practices. The decision to retain a small or large firm, a firm with specialized expertise or a firm with a broad array of services requires a balancing of several factors.

Large consulting firms offer advantages including the ability to provide a broad range of services and draw upon a large number of consultants, often through a network of offices. Because of the size of these firms, they are also able to ensure a certain sense of continuity, both throughout the project and in providing necessary follow-up or related services.

Larger firms often have higher overhead expenses which can translate into higher fees for clients and sometimes rely on younger, less seasoned consultants to carry out major portions of their assignments. Careful negotiation of fees and close attention to the issue of who will provide services can effectively neutralize these factors.

Small firms can offer more personalized, specialized service but often cannot offer as complete an array of services. With a smaller firm, it may be more important to focus on issues involving the stability of the firm and the firm's ability to ensure continuity if something happens to the consultant on your project.

When colleagues recommend a consultant, ask these questions:

•Were they pleased with the consultant's performance?

•What were the consultant's strengths and weaknesses?

•Was the project completed in a timely manner?

•Was the consultant accessible? (For example, were phone calls returned promptly?)

•Were there any aspects of the consultant's work with which they were dissatisfied?

•Would they use the consultant again?

What should it cost?

The fee a consulting firm quotes for a project obviously is a significant factor. Consultants generally charge for their services by the hour or by the project. Depending on their qualifications and expertise, most consultants bill at a rate of between $100 and $200 per hour.

Other factors that can influence the billing rate include the size of the project and the prospect of future engagements from the client.

When an hourly rate is quoted, get an estimate of the total cost of the project and, if possible, a "not to exceed" provision in the contract. Requesting a project bid rather than an hourly bid may be a better way to "fix" your consulting costs at the start of the project.

It is important to be clear on precisely what services are included in the fee. If the scope of the project is not clearly defined in the written proposal, the consultant should be asked to set out a more specific description of services. It is also important to specify what expenses will be reimbursed as part of the project.

Reasonable travel expenses including airfare, ground transportation, lodging and meals are typically reimbursed, but it can be helpful to specify what is meant by "reasonable" (for example, coach airfare, mid-size care rental, etc.). Some consultants expect to be reimbursed for other expenses such as document reproduction, long distance telephone calls and postage. To avoid conflicts, discuss this at the outset and include appropriate language.

Some consultants expect to be reimbursed for other expenses such as document reproduction, long distance calls and postage.

Interviewing the consultant

Consultants come in all sizes, shapes and personalities and, despite the appearance of the right "fit" on paper, it is critical that the relationship feel right. The consultant will work closely with the physician, typically over a period of many months, and often will be involved in sensitive discussions and decisions regarding issues fundamental to the physician's professional life. The individual must be someone the physician can trust with confidential information.

It's important to have a face-to-face interview with a potential consultant if at all possible. Most consultants will absorb any travel expenses associated with a presentation to a potential client; others request that such expenses be reimbursed. If a group of physicians is retaining a consultant, all or several of them should be involved in the selection process. While not ideal, the interview sometimes is conducted through a telephone conference call.

The consulting agreement

A consulting project of any significance should be covered by a written agreement to reduce the potential for conflict over the terms of the engagement. This document should be prepared or reviewed by your attorney and should contain appropriate language addressing each of the points discussed in this article.

Although the consultant search process can be time-consuming, careful attention to the process is time well spent.

FUTURES

How capitation works

NOTE: This article is excerpted from a presentation by consultant William DeMarco to the National Association of Managed Care Physicians and the American Association of Physician Hospital Organizations earlier this year. Mr. DeMarco was a guest speaker at the Iowa Medical Society's October 27 Des Moines conference "Organizing for Change".

What is "Capitation"?

Capitation is a way to pay for health care services in which physicians and other providers accept a fixed payment per subscriber, per period of time, in exchange for specified services.



WILLIAM DEMARCO
Mr. DeMarco is president and CEO of DeMarco & Associates in Rockford, Illinois. The firm offers a variety of services to physicians, including organizational development, marketing strategy and operational planning and effectiveness.

Capitation payment may not be the last frontier but it is the new frontier for many of us. There is a tremendous shift from the discounted fee-for-service to some sort of capitation model. Capitation comes in different flavors and shapes and I'd like to share with you what employers are telling me about long-term cost containment through capitation.

Reimbursement tied to structure

In the old days, reimbursement was tied strictly to structure. The idea was that the more risk the provider took, the more market share the payer was supposed to get. In reality, that isn't always the case. That risk and reward element isn't always there — partly because of negotiating and partly because of ill-defined products.

Capitation came about because of the employers' desire to contain costs. Group models came with this capitation approach because the incentive changed with fixed price reimbursement. The issue became the number of people that physicians are accountable for.

Another factor is something employers have learned about salaried physicians. If you take 10 physicians who have been seeing 30 patients a day and tell them they'll be paid $200,000 per year no matter how many patients they see, a civil service mentality sometimes takes over. If you don't have a performance pay system, you have no way to identify the top performer in the group.

Predictable costs for employers

Under capitation and other fixed price agreements, employers will continue to push down on the fee they are willing to pay for health care. Employers believe there is fat in the system and that inefficiency should mean a loss of profits for the providers. In other words, the economics of medicine have changed.

There is a long list of reasons why physician practice expenses have gone up. When you look at the expenses that go into managing a practice and factor in the expected reductions in physician income, it's not surprising that more physicians are looking at groups of at least five or six physicians. There is tremendous interest in consolidation into single specialty or multispecialty group practices.

What's happening now is that price pressure from managed care is actually changing the

dynamics of fee-for-service. If an HMO has 10% of the market in a physician's service area, that physician's per patient income will be fairly stable, or may go down 1%. However, when the HMO hits 15-25% saturation, the same physician is going to see his/her average income per patient start to drop. Why? Because to keep all the employers happy the insurance company has to reduce its 'usual and customary' rates. These insurance company's rates — which once were the norm in the market — now start to resemble the HMO fee schedule.

Unless they have an action plan, physicians will eventually get to a place where they will see serious drops in income. We have seen examples of specialty incomes dropping 9%. Many physicians are asking why managed care is trying to keep patients away and this is, in fact, what managed care companies are doing. To an HMO, the family practice physician looks like the best bet for saving money and creating a more visible premium in the market because average tests ordered, average admissions per 1,000 and average tests per patient are lower than for specialists.

In an aggressive capitated system, 2,300 patients is not an unusual number of charts to be responsible for.

The numbers game

If I were to ask any 30 or 40 physicians to give me an accurate estimate of the number of charts they are responsible for, the average is going to be about 500 active charts per practice, a bit less for specialists and a bit more for primary care physicians. In an aggressive HMO setting, the theory is they will have more physicians with more patients. In other words, they will assign 800 patients per physician rather than 500.

In an aggressive capitated system, 2,300 patients is not unusual. That doesn't mean you see all those patients, but you are accountable for them. Herein lies the risk in capitation. If you are receiving the nationwide capitation average of $74 per patient per month and you get 2,300 very sick patients, you are in serious trouble if you haven't budgeted in advance for those expenditures. There isn't a physician I've talked with who hasn't identified this as one of the key concerns with capitation.

This is a big issue when you begin valuing practices because many physicians are using the old method of doing this. They estimate the value of their bricks and mortar, their goodwill, the number of patients, etc. That's fine in the fee-for-service environment, but under capitation, income is determined by the number of charts you are responsible for. Now we know why large hospitals and universities are out buying practices. They are betting they can fill that practice with capitation. Would you give me $200,000 if I give you $800,000 in a couple years? Of course, because that's a very good investment and the hospitals know it.

So, you see how important it is to be effective at moving into capitation and allocating patients in a way that is conducive for the physician's practice.

Where have all the patients gone?

There is a dark side to all this, one physicians ask me about frequently. What if the entire country went to capitation tomorrow? Where would all the patients come from? Obviously, managed care doesn't have a warehouse where patients are manufactured. The truth is, if

FUTURES

everyone went to capitation tomorrow, about 40% of physicians now practicing or in medical school would not be needed. That's scary. Even primary care would be overstaffed in some areas. It will be more gradual than this, but eventually there will be winners (those locked in to capitation) and there will be losers (those locked out of capitation) on a market to market basis.

Capitation is a perfect way to reconcile differences between primary care and specialty care.

Cooperation between primary care, specialties

Capitation is a perfect way to reconcile differences between primary and specialty care. Capitation operates on the contention that primary care physicians will put themselves at risk up front to do certain services for a certain number of patients. These primary care physicians don't really have a reason to do all the other things the specialists are doing. In a cooperative arrangement between primary care physicians and specialists, the specialists see an actual cash flow right from the primary care physicians. Ten or 15 primary care physicians who see 3,000 patients each will keep those specialists very busy.

So, you can prosper under capitation, but you also should consider that the more you profit, the more likely it is that someone will change the rules. For this reason, there are many PHOs which are making money but are keeping it to themselves and disbursing it back to the physicians or keeping it in deferred compensation accounts for research and development or future projects.

The problem is, capitation is different for every type of physician. Our subsidiary corporation Warren Surveys tracks 22 medical specialties and they report their capitation amounts on a confidential basis. There is a tremendous array in these amounts.

The bottom line is, as a primary care physician, would you rather receive $18 per member per month for 3,200 patients assigned to you or would you rather receive $75 per member per month?

The physicians getting the $18 per month are responsible for a couple of office visits, vaccinations and maybe some prescription drugs. I recently examined a contract from Alabama, and the proposal from the HMO was that the physicians were at risk for all the services their specialty provides. That might mean different things to different health plans in terms of what they think a urologist does or what they think a primary care physician should do.

In fact, the definition of primary care physician can vary from plan to plan. One physician told me it took six months for pediatrics to be elected as a primary care specialty in his PHO.

Taking the full cap

At the far end of $75, you are taking the full cap. This means you are responsible for the full range of care, including specialty care and hospital care. Those dollars belong to the primary care physicians and they are free to find specialists to operate on a discount fee sched-

ule with them or find a hospital that can be a partner on a discount DRG basis. If they can do all this within a budget, the dollars saved belong to them. For example, I know of a group of four obstetricians in Chicago who take all the OB business in that part of the city and they have done extremely well.

Recently, I asked a large group of underwriters and insurance executives if they had figured out capitation rates for the physician practices they are associated with and about two hands were raised. So, if you think the insurance companies know all about how this is calculated, think again. They sometimes don't have the clinical basis for a lot of the assumptions they are making. You need to know this if you are intending to seriously negotiate a favorable relationship for the physicians in your organization.

If you think insurance companies know all about how this is calculated, think again. They don't have a basis for a lot of the assumptions they are making.

How can you get into trouble in these negotiations? One way is if you have an adverse patient population, or patients who use services more than the budget allows. One thing we have learned about an insurance product is that people behave differently depending upon the restrictions of the product. For example, if there is a deductible in the HMO setting, the average visits per patient go down; but, most of the time, there is not. This points up the need to have a good data system so that when you negotiate, you have the facts you need.

The second way to get into trouble is charges. Our experience with Medicaid has taught us that when they said they would pay 100% of usual and customary, they weren't talking about your usual and customary. HMOs and managed care companies may operate in the same way. When they tell you the capitation rate will be based on 80% of the usual and customary, you need to find out whose usual and customary they are referring to.

The problem is that what is reasonable and customary is never usual anymore. This means you have to do some work in advance of negotiating. Research the general market and develop a unilateral proposal for your organization. Don't wait for the managed care company to come to you because you will be on the defensive.

Choosing a risk level

It is possible to choose the services you will be responsible for under capitation. A primary care physician may look at the managed care contract and find he or she is responsible for laboratory, x-rays and all kinds of unanticipated things. You can carve those out. You can offer to take the risk for a half a dozen procedures. You will want to focus on procedures you are familiar with — procedures for which you can accurately predict costs and volume. Carving those out and knowing exactly what procedures will be included before you negotiate is a lot more precise than trying to settle it after the contract is negotiated.

Capitation can help the primary and specialty physicians work out who is going to be responsible for what services. In any relationship, defining roles is the most difficult part. In a capitation relationship between primary and specialty physicians, we're using the financing mechanism to our advantage. IM

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Kurt V. Gold, M.D.

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Kurt V. Gold, M.D., received a doctorate of medicine from the University of California, Irvine. He also received pediatric specialty training from the University of California, Irvine, plus physical medicine and rehabilitation training from Loma Linda University Medical Center and Jerry L. Pettis Memorial V.A. Hospital.

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The Journal
of the Iowa Medical Society

Primary malignant melanoma of the lower lip

● AHMED GHOURI, MD; DARREN KILLEN, MD; RICHARD FIRKINS, MD; KULACHANDRA DEVAIAH, MD

A 63-year-old Caucasian male was seen at the Veterans Affairs Medical Center in October 1990 for a non-healing lesion on his lower lip. The painful lesion had been present for approximately four months, and had been bleeding. It did not arise within an area of previously known pigmentation. There was no family history of cancer; the patient denied significant tobacco or ethanol use.

A 15 mm, crusty, ulcerated, friable lesion was noted on the vermilion border of the right side of the lower lip. No neck masses were palpable. A biopsy showed poorly-differentiated squamous cell carcinoma. A wedge resection of the lower lip was interpreted as a spindle cell carcinoma, with margins free of tumor.

In May 1991 the patient developed an enlarging right neck mass. Examination revealed a 3 cm hard, nontender mass in the right neck just inferior to the mandible. He underwent right suprahyoid neck dissection, and one of four sampled lymph nodes was positive for metastatic spindle cell carcinoma with histological features similar to the lip lesion.

The Armed Forces Institute of Pathology in Washington D.C. examined the specimens and diagnosed spindle-cell malignant melanoma. The histological examination revealed a nested pattern of tumor cells and a lack of definite keratinization. An immunoperoxidase stain for S-100 protein was positive. The depth of the stage III tumor was 9.0 mm, corresponding to Clark's level V.[1]

In November 1991 the patient complained of right neck soreness but no further masses were felt. In March 1992 a new skin lesion below his left eye was surgically excised and found to be a basal cell carcinoma.

In June 1992 the patient was admitted for elective left total knee replacement. A routine chest X-ray revealed multiple pulmonary lesions in both lung fields (Figure 1). A subsequent CT scan confirmed these lesions and a needle biopsy demonstrated metastatic spindle cell melanoma. Abdominal and head CTs, as well as a ^{99}Te bone scan, were negative.

When the patient completed his first course of systemic chemotherapy, the pulmonary lesions had decreased by 50%. However, in July, 1992 he complained of swelling in his right neck, which was felt to represent a hematoma or lymphadenopathy. Partial resolution occurred with a course of oral antibiotics. The patient refused further chemotherapy, complaining of lethargy, nausea, vomiting and loss of appetite. In October 1992 he was



Figure 1. Lateral chest x-ray taken 20 months following resection of primary melanoma for the lower lip. Pulmonary metastatic lesions are evident.

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for November 1994.

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Primary malignant melanoma of the lower lip

continued

admitted at an outside hospital for two weeks following an accidental gunshot wound. He recovered from this but died at home in November 1992 of metastatic disease.

Pathogenesis

Head and neck melanomas develop from the malignant transformation of the melanocyte, a pigment-producing cell of neural crest origin.[2]

By four to six weeks of fetal development, melanocytes have migrated to their final destinations which include the uveal tract, meninges, skin and ectodermal mucosa.[3] The ability of melanocytes to migrate easily through tissues during embryogenesis may be related to the aggressive capability of melanomas to metastasize widely and rapidly.[4] In adults, melanocytes are epithelial and mostly located at the dermal-epidermal junction of the skin as well as in the eye. However, melanocytes can be identified in the meninges, in the aerodigestive tracts and in lymph nodes, thus explaining the occurence of primary melanomas in these locations.[5]

Histologically, melanoma of the head and neck (including that of the oral cavity) is frequently indistinguishable from that originating in the extremities.[6] However, some authors have pointed out a higher degree of pleomorphism and mitosis in mucous-membrane lesions of the head and neck than in lesions of the skin.[7] This observation may explain the frequent difficulty in diagnosing these tumors, as well as the observation that mucous membrane melanomas are more aggressive and lethal.

Melanoma of the head and neck is a rare disease and few centers have accumulated significant data. Mucosal melanomas account for less than 5% of of all melanomas.[8] Adachi was the first to note that melanocytes normally occur in the oral mucosa.[9] In 1966, Lane-Brown and coworkers were able to grow normal melanocytes from the mucosa of the oral cavity in tissue culture.[10] It is reasonable to believe that primary melanoma may arise de novo from the oral mucosa.

Among oral melanomas, the mucosa of the maxilla is the most common site, representing up to 70-80% of cases.[6, 11-13] No satisfactory explanation has been proposed for this observation. While the lip is the least common location of oral malignant melanoma, it is the most common site of benign oral melanotic lesions.[14] The vast majority of melanotic lip lesions are benign.[15] These lesions typically involve the vermilion border and not the lining mucosa itself. Virtually all lip tumors are either squamous cell carcinomas, basal cell carcinomas that have extended from the skin of the lip onto the labial surface or tumors of the minor salivary glands.[16-17]

Risk factors

There are several independent risk factors associated with development of melanoma.

Patients with melanoma have a fair complexion and a tendency to sunburn. Red hair, blond hair and a fair complexion increase risk by 300%, 60%, and 200%, respectively. Patients with more than 20 nevi have a three-fold increase in relative risk.[18] A history of melanoma increases the chance of developing a second melanoma by 900 times versus the general population.[19]

Other findings implicate hereditary factors in melanoma. Several authors have described increased frequencies of blood, complement and HLA phenotypes in melanoma patients, suggesting a genetic predisposition in these individuals.[20-25] Recent evidence has shown that melanoma cells taken from both primary and metastatic lesions contain nonrandom DNA alterations in the short arm of chromosome 1 (1p), both arms of chromosome 6 and chromosome 7.[26-28]

Histologic classification

Malignant melanoma (including that occurring in the head and neck) is usually classified into four categories based on microscopic growth patterns. These are melanoma arising in lentigo maligna, superficial spreading melanoma, nodular melanoma and acro-lentiginous melanoma.[1]

Our patient presented with a rare, spindle-cell form of melanoma that does not fall into any of the above classifications. Spindle cell melanoma is often described as containing poorly-differentiated tumor cells which contain spindle-shaped, hyperchromatic, and polygonal nuclei as well as prominent nucleoli.[29-32] The cytoplasm of the tumor cells may appear eosinophilic, and many mitotic figures

(often atypical) are present. Spindle cell melanomas may stain negative for HMB-45, an immunostain frequently used as a melanoma marker.[32]

Diagnosis and staging

Any lesion involving the head and neck which changes in size, color, configuration, or appearance should be considered a potential melanoma and biopsied, either excisional or by core-punch. The typical macroscopic features of melanomas include (a) an irregular raised surface, (b) variability in color, (c) an irregular border, and (d) ulceration of the surface epithelium.

Moore and Martin reported 12 cases of malignant melanoma of the oral cavity.[33] They concluded that patients and physicians are frequently unaware of the serious nature of pigmentation in the oral cavity, especially in cases in which it has been present for a significant length of time. A very high index of suspicion is warranted for pigmented lesions of the head and neck, including those of the oral cavity and mucous membranes.

Staging of malignant melanoma follows the tumor-node-metastasis (TNM) classification system.[1] Following biopsy, the pathological specimen is used to determine both the tumor's thickness (Breslow's microstaging) and microscopic level of invasion through anatomic boundaries (Clark's microstaging).[1] Breslow's system is a quantitative assessment of maximum tumor thickness in millimeters as measured by an ocular micrometer. In 1985, the American Joint Committee on Cancer (AJCC) adopted a new staging system for malignant melanoma that considers both Breslow's and Clark's level as well as regional nodal disease and metastasis[1] (Table 1).

Methods of treatment

Conventional radiation therapy has little role in the treatment of primary lesions and surgery is the only definitive treatment.[34] Tumor thickness is the primary criterion in determining the extent of surgical resection. For all lesions, at least a 1-2 cm margin is desired.[35] For melanomas greater than 1 mm in thickness, a 3 to 4 cm excisional margin may be necessary to prevent local recurrence and satellitosis.[35] This can be very difficult and often impossible for lesions involving the head and neck because of anatomical and functional considerations. It has been estimated that the overall risk of local recurrence for primary melanomas with adequate margins is 3%.[1]

The presence of suspected cervical node metastases requires special consideration in the management of head and neck melanoma. In general, radical neck dissection is employed whenever nodal disease is clinically evident at the time of initial presentation. The pattern of lymph node metastasis from primary head and neck melanomas is often reliably predicted based on anatomical drainage.[35]

Whether or not to perform a modified versus radical neck dissection is controversial (the modified approach spares the sternocleidomastoid and spinal accessory nerve).[36] Many surgeons commonly perform the modified technique based on extrapolation of results involving patients with squamous cell carcinoma of the head and neck.[37-38] While the modified technique offers better postoperative shoulder function and a good cosmetic result, no comparative study has evaluated modified versus radical neck dissection for the treatment of melanoma.[8]

Aggressive local treatment, especially for head and neck tumors, is far more effective than systemic therapy.[8] Radiation therapy, chemotherapy and immunotherapy are generally reserved for treatment of metastatic disease, although surgery can be advantageous for one or a few metastatic lesions. Even when multiple lesions are present, surgery may offer significant palliation.

TABLE 1
STAGING OF MELANOMA (AMERICAN JOINT COMMITTEE ON CANCER)[1]

Stage	*Criteria*
IA	Localized melanoma < 0.75 mm or Level II (T1 N0 M0)*
IB	Localized melanoma 0.76 to 1.50 mm or Level III (T2 N0 M0)*
IIA	Localized melanoma 1.5 mm to 4.0 mm or Level IV (T3 N0 M0)*
IIB	Localized melanoma > 4 mm or Level V (T4 N0 M0)*
III	Limited nodal metastases involving only one regional lymph node basin or <5 in-transit metastases but without nodal metastases (any T, N1, M0)
IV	Advanced regional metastases (any T, N2, M0) or any patient with distant metastases (any T, any N, M1 or M2)

** When the thickness and level of invasion criteria do not coincide within a T classification, thickness of the lesion should take precedence*

Primary malignant melanoma of the lower lip

continued

The imidazole carboxamide (DTIC) is considered the standard single agent for treatment of disseminated melanoma, although the response rate is small (15-20%).[39] Although combination therapy is also used, its efficacy remains controversial.

Extensive metastases (especially bone pain) can often be palliated with radiation therapy. CNS lesions are sometimes successfully controlled with cranial and spinal cord irradiation combined with dexamethasone therapy.[1]

Although intralesional immunotherapy using nonspecific agents has been used with some success, effective systemic therapy for metastatic melanoma does not exist.[40-42] The development of sophisticated recombinant DNA technology has led to the investigation of numerous immunologically-based strategies which are experimental but promising.

Prognosis

The major predictors of outcome in patients with malignant melanoma, shown in Table 2, are applicable to head and neck lesions.[1] For Stage IA lesions, the five-year survival was 55% if elective neck dissection was performed, versus only 38.5% if not performed.[43] Thus, early lesions combined with an aggressive surgical approach can be successfully treated in a significant number of individuals.

However, not all melanomas behave the same. For example, the prognosis of patients with melanoma of the oral cavity or mucous membranes is generally very poor. McCaffrey et al have postulated several reasons why the prognosis is exceptionally poor for oral melanomas: (a) symptoms of pain and bleeding happen only after the tumor is relatively advanced, (b) wide excision of intraoral lesions is technically difficult or impossible, (c) mucous membrane melanomas may be inheritantly more aggressive than cutaneous melanomas and (d) the rich blood supply of the oral cavity may permit early hematogenous dissemin-ation.[44] Thus, it was not surprising that the patient presented in this case report progressed to develop metastatic disease, despite surgical margins that were free of tumor.

TABLE 2
MAJOR PROGNOSTIC FACTORS IN MELANOMA FROM HOLLEB ET AL)[1]

Clinical factors	*Unfavorable predictors*
Localized melanoma	
tumor thickness	>1.5 mm depth of invasion
ulceration	present
sex	male
location	trunk or mucous membranes
Regional disease	
number of positive nodes	>1
ulceration of primary	present
Distant metastases	
location	visceral
number of sites	>1

Summary

Melanomas in the anatomically complex area of the head and neck impose formidable obstacles to treatment. Mucosal melanomas, for reasons which remain uncertain, are associated with a poorer prognosis. Because no systemic treatment is known to be effective, increased awareness by patients and a high index of suspicion is warranted. The disease is potentially curable if diagnosed and treated at an early stage.

References

References noted in this article are available from the authors or the editors of *Iowa Medicine.*

Your future by choice, not by fate

Remember this also, and be well persuaded of its truth: the future is not in the hands of Fate, but in ours.

Jules Jusserand (1885-1932)
French statesman and man of letters

I never think of the future. It comes soon enough.

Albert Einstein (1879-1955)

No one can tell what the future may bring.

Demosthenes (385-322 B.C.)
Greek orator

Doctors, did you read the articles in the September and the October issues of *Iowa Medicine* about your professional future? Did you attend any of the five regional meetings in September? Did you attend the statewide futures program "Organizing for Change" held in Des Moines on October 27? Have you developed strategies for tomorrow's practice? As noted in the introductory quotations, concern for the future may be negative or positive. Some accept what comes as it comes. Others make plans with strategies designed to cope with whatever happens. Still others look for ways to alter the future.

All of us want to be ensured of success in our practice. As elucidated in the lead article in the September issue of *Iowa Medicine* (page 389) one may use E S P to predict your future in medicine: Explore your environment, Study your options and Prepare your strategy. How you go about making such a prediction depends on your individual situation. Some think they know all the answers, unaware of the pitfalls which can be overlooked even by an astute student of practice management. One must be willing to adequately assess individual plans. Proper advise and consultation is paramount in concerns for the future. I repeat the admonition given on page 391 of the aforementioned *Iowa Medicine*: "Given the proper advice, physicians can take the lead and control their professional destinies. Given inappropriate advice, physicians risk losing the investment they have made . . . opportunities and options that may not be available in the future."

We cannot in all good consciousness stand aside and let our future be determined by those outside our honorable profession. Einstein was not wise. To never think of the future is foolish. Demosthenes should have gone farther; though one cannot tell what the future may bring, one should at least attempt to control it. Jusserand stated it more aptly, "the future is not in the hands of Fate, but in ours."

We cannot stand aside and let our future be determined by those outside our profession.

Which course do you propose to follow, Doctor? Be involved, work together and listen to appropriate advice. Remember, your future is in the collective hands of our entire profession. IM



MARION ALBERTS, MD



FRONT ROW: Ruth Clare, Bernie Lowe, Mary Sievers
BACK ROW: Terri DeGroot, Don Neumann, Patty DeFrancisco

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An Osler year

I've had an Osler year. Sir William Osler (1849-1919), Canadian-born, was the best known and admired physician in the English-speaking world from the 1880s until well into this century.

His name first came to my ears via Dr. William Bennett Bean, head of internal medicine at the University of Iowa, when I was a medical student. Dr. Bean was founding president of the American Osler Society, an organization of persons interested in perpetuating the memory of the man and his ideals. I have since become a member and have learned much. For instance, those interested in eponyms may recall "Osler's nodes" (inflammatory nodules of the fingertips seen in some instances of SBE) or the "Osler-Rendu-Weber syndrome" (hereditary hemorrhagic telangiectasia).

Osler became the founding internist and chief of staff for the Johns Hopkins medical school and hospital when they were begun in the 1890s. That began a revolution in American medical education by introducing scientific research and bedside teaching into the experience of medical students and their teachers. His 1892 textbook, *Principles and Practice of Medicine*, dominated medical textbooks for 40 years.

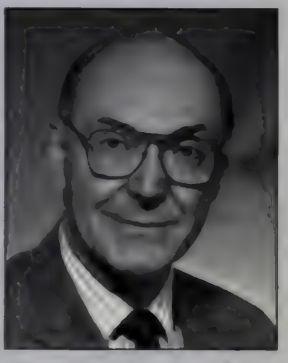
That began a revolution in American Medical Education.

I often encounter references to Osler, his professional career, his medical and philosophically-tinged writings that evidenced an enormous interest in medical history and classical learning, and to his personal library of rare books and manuscripts that he bequeathed to the library of his alma mater, McGill University. The books and other memorabilia are available yet for your perusal in Montreal.

In the past year two major milestones securely planted his biography into my long-term memory: first, I finally read neurosurgeon Harvey Cushing's enormous, Pulitzer prizewinning biography of Osler published in 1925; and second, I visited Osler's venue in Oxford, England, along with other members of the American Osler Society.

Nobody could get away with a biography like Cushing's anymore—1,372 big pages of fine print, incorporating a huge number of letters to and from Osler. Today's style would require greater selectivity and less obvious adulation.

Visiting the Radcliffe Infirmary in Oxford, where Osler held forth as a teacher-clinician; drinking tea at 13 Norham Gardens, where he lived and accumulated his amazing personal library; strolling the grounds of Christchurch, the Oxonian College which he served as Master; and seeing the 12th century village church at Ewelme and its almshouse for elderly men, for which Osler served as honorary master—all these enlivened what I had come to learn and remember of this great physician. It is his scholarly, wise essays plus his humor and down-to-earth ways, however, not his great textbook or the torrent of other medical writings, which will remain to inspire the future readers of this superbly prepared, exemplary humanistic physician and teacher. IM



Richard Caplan, MD

Classified Advertising

Emergency Medicine Co-Director • Ottumwa, Iowa

Exceptional opportunity for primary care trained or experienced emergency physician. Ottumwa Regional Health Center is a 275-bed facility serving an 8 county area in SE Iowa and NE Missouri. 21,000 volume/12 and 16 hour shifts with double coverage at peak times. Excellent medical backup is provided by a medical staff of 50 physicians representing a broad range of specialties. Rathbun Lake, a beautiful 11,000 acre lake, is 40 miles from Ottumwa and offers an abundance of recreational activities. Midwestern hospitality, safe living and award winning schools make Ottumwa a place to call "home." Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Mankato Clinic, Ltd.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 65-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President, at 507/389-8500 or Anthony C. Jaspers, President, at 507/726-2136 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

Marshalltown, Iowa

Best of both worlds—rural small group atmosphere, urban large group amenities. Seeking quality emergency physicians interested in stellar emergency medicine practice. Full-time and regular part-time. 12K volume/12-hour shifts. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses for full-time. Numerous other Iowa locales. **ACUTE CARE, INC.,** P.O. Box 515, Ankeny, Iowa 50021; 800/729-7813 or 515/964-2772.

Office Closed—Due to illness. Must sell furniture, equipment and supplies, including EKG and Doppler from Peripheral Vasculary Studies, reception room, secretary's area, 3 exam rooms and physicians's consultation room. Fine original prints (not reprodutions) and other art pieces from office also availalbe. Call 319/372-3083 for more information.

Emergency Medicine Locum Tenens

Seeking quality physicians interested in emergency medicine practice or primary care locum tenens. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact **ACUTE CARE, INC.,** P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

EXPLORE THE POSSIBILITIES!

We are currently seeking primary care physicians specializing in Family Medicine, Pediatrics, Occupational Medicine, Internal Medicine and OB/GYN for a variety of group practices throughout the Midwest and New York State. Surgical and subspecialty physicians are also needed for a variety of locations. We represent practices in all types of settings in communities of every size. New opportunities become available every month. Whether a practice change is imminent, or just a future consideration, we have the information you need.

Strelcheck & Associates, Inc.
10624 N. Port Washington Road
Mequon, Wisconsin 53092
1/800-243-4353

Practice Announcement

Mark A. Templeton announces the establishment of his private legal practice at 1003 Grand Avenue, West Des Moines, Iowa 50265. This office building is immediately west of the Iowa Medical Society headquarters.

Appointments are being accepted by calling 515/224-4639.

Mark was previously employed by the Iowa Medical Society as manager of specialty services.

The determination of the need for legal service and the choice of a lawyer are extremely important decisions and should not be based solely upon advertisements of self-proclaimed expertise. This disclosure is required by rule of the Supreme Court of Iowa.

Sioux City—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. FEDERAL LOAN REPAYMENT PROGRAM AVAILABLE. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712/252-2477.

Family Practice, Carroll, Iowa—Outstanding professional opportunity for family practice physicians in a progressive, safe and clean community of 10,000. These opportunities are availalbe for either expierenced family practice physicians, or the family practice physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential availalbe. For more informtion, call Randy Simmons, Vice President, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

Emergency Medicine
Fort Dodge, Iowa

Immediate opportunity for primary care trained or experienced emergency physician. Trinity Regional Hospital is a 200-bed facility acting as a regional referral center for northwest Iowa. 15,000 annual volume/24-hour shifts. Medical backup is diverse with a full range of specialists represented. Ft. Dodge, a community of 26,000 nested in the beautiful Des Moines River valley, is the commercial hub of north central Iowa. Ft. Dodge provides a warm friendly community in which to live and raise a family. An outstanding compensation package includes health/dental, life, disability, malpractice insurances. Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.

Family Practitioner—McFarland Clinic is actively recruiting a BE/BC family practice physician to assume the responsibilities of an established family medicine practice in central Iowa. Practitioner has support of over 80 medical and surgical sub-specialty physicians in same multispecialty group. Full privileges for a residency-trained family physician at Mary Greeley Medical Center, a 200-bed hospital in Ames, Iowa. Night call on a rotating basis at the Emergency Room at MGMC. McFarland Clinic offers distinct advantages for the practicing physician in providing excellent compensation and benefits, practice management services and a generous retirement program, all in an environment which emphasizes physician cooperation and teamwork. For additional information, call or submit CV to Karen Andersen, 515/239-4535, McFarland Clinic, P.C., 1215 Duff Avenue, Ames, Iowa 50010.

Excellent practice opportunities—In Minnesota and western Wisconsin communities. Primary care and specialties. For more information, call 1-800/248-4921.

Boone, Iowa

Seeking a quality emergency physician interested in a stellar emergency medicine practice. Full and regular part-time position available. Democratic group, paid St. Paul malpractice with unlimited tail. Excellent benefit package/bonuses to full-time physicians. Average volume with above-average compensation. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Family Practice, Fairfield, Iowa—Over $100,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

LeMars, Iowa

Seeking quality physicians to practice at a 4300 average volume ER. Director and staff positions. Full and regular part-time. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. **Acute Care, Inc.**, P.O. Box 515, Ankeny, Iowa 50021; phone 800/729-7813.

Venture North—To the northwest suburbs of the Twin Cities, Minnesota. Full and part-time positions are available for BC/BE physicians in FP, IM and OB/GYN and for physician assistants and nurse practitioners. Get back on course with the owned and affiliated clinics of North Memorial Medical Center. Choose large, small, urban or semi-rural practices. Plus, receive up to $15,000 (extenders up to $10,000) on start date through our community service program. If interested, send CV or call in confidence to North Medical Programs, North Memorial Medical Center, 3300 Oakdale Avenue North, Robbinsdale, Minnesota 55422-2900; 800/275-4790.

Family Practice Physician—Rare opportunity for a BE/BC family practice physician to join an established, progressive 8-physician practice in Marshalltown, Iowa, a thriving family oriented community 40 miles northeast of Des Moines. We have a beautiful new facility, a qualified staff and enjoy a supportive relationship with our 176-bed local hospital. Our philosophy is to provide personal, quality care to each of our patients, while maintaining our productivity, profitability and efficiency. This position offers an excellent benefit package, a voice in decision-making, 1 in 8 call and a very competitive salary/dividend package. For more information call or write to Michael Miriovsky, MD or James Burke, MD, Center for Family Medicine, PLC, 312 E. Main Street, Marshalltown, Iowa 50158 or call 515/752-5469.

Emergency Medicine
Burlington, Iowa

Outstanding opportunity in emergency medicine for primary care trained or experienced emergency physician. Burlington Medical Center is a 239-bed facility serving a multi-county area in SE Iowa, NE Missouri and western Illinois. 19,000 volume/double coverage at peak times. BMC medical staff consists of 80 physicians representing a broad range of specialties. Burlington, a community of 30,000, sits on the banks of the Mississippi River with commanding river views giving way to wide open horizons. Cultural opportunities take many forms from art and history museums to Mississippi River festivals and SE Iowa Symphony Orchestra to the Iowa state chili cook-off. Iowa's reputation for quality education is reflected in the Burlington schools. Burlington is a community where balance between family and career is easy to maintain. Guaranteed minimum compensation package including paid malpractice. **Send CV or call Sheila Jorgensen, Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704; 800/458-5003.**

Family Practice, Estherville, Iowa—Well-established group of 5 family practitioners is recruiting a partner. Busy practice with the full range of services, including obstetrics and ER. Competitive financial package. Comfortable rural community of 7,000 people located minutes away from Spirit and Okoboji Lakes. Fabulous recreational opportunities available. Solid work force. Good schools. Low crime area. For more information, contact Christopher Kashnig, Physician Recruiter, PO Box 1100, Oshkosh, Wisconsin 54902. Call 414/236-2430, fax 414/236-1312.

(Continued next page)

Advertising Rates and Data

Regular classified advertising sells for $2.00 per line with a $30 minimum per insertion. For members of the Iowa Medical Society the rate is $20 per insertion. Display classified advertising sells for $25 per column inch, per month. Sizes range from 1 column by 2 inches to 1 column by 6 inches. A variety of type sizes, borders, reverses or screens can be included in the ad. Blind box numbers are available upon request at no additional charge. Copy deadline is the 1st of the month preceding publication. Send or fax copy to Iowa Medicine, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Internal Medicine, Carroll, Iowa—Outstanding professional opportunity for an internal medicine physician in a progressive, safe and clean community of 10,000. This opportunity is available for either practicing internal medicine physician, or the internal medicine physician just beginning practice. Excellent schools (Catholic and public), quality hospital and significant income potential available. For more informtion, call Randy Simmons, vice president, at 1-800/382-4197 or write St. Anthony Regional Hospital, South Clark Street, Carroll, Iowa 51401.

BC/BE Internist—For 84-physician multispecialty group on the scenic bluffs overlooking the Mississippi River where Iowa, Illinois and Wisconsin meet. Excellent call schedule in this 17-member department of physician-owned clinic with its own HMO. Professional administration enables physicians to concentrate on the practice of medicine. Outstanding lifestyle, excellent income guarantee, complete benefits and ownership eligibility. Call or send CV to Denis Albright, Medical Associates Clinic, 1000 Langworthy, Dubuque, Iowa 52001; 800/648-6868.

Student Health Service Psychiatrist—To provide psychiatric evaluation and outpatient psychiatric treatment for students attending the University of Iowa who seek these services. Satisfactory completion of residency requirements for board eligibility in psychiatry is required. Send CV to Mary Khowassah, MD, Student Health Service, University of Iowa, Iowa City, Iowa 52242. The University of Iowa is an Affirmative Action/Equal Opportunity Employer. Women and minorities are encouraged to apply.

General Surgeon, Creston, Iowa—An opening for a third BC/BE surgeon in a very busy general surgery practice located 1 hour from Des Moines, Iowa. Two-surgeon department, expanding to 3 due to work load, is associated with 13 other physicians. Salary and benefit package very lucrative including moving expenses and full partnership within 1 to 2 years with limited call duty. Country living in a community of 9,000 with excellent educational system, recreation, low crime rate and lifestyle not found in metro areas. Contact Mike Brentnall, 515/782-2131 or send CV to Creston Medical Clinic, PC, 526 New York Avenue, Creston, Iowa 50801.

MERCY/MAYO FAMILY PRACTICE RESIDENCY PROGRAM DIRECTOR

Mercy Hospital Medical Center of Des Moines, Iowa, and Mayo Graduate School of Medicine seek a program director for their family practice residency program. The program will begin accepting residents in 1997 and will provide comprehensive training utilizing the inpatient and outpatient facilities of the Mercy clinic system.

Candidates must be currently certified by the American Board of Family Practice Physicians and have a minimum of two years' full-time professional activity in family practice medicine. Teaching experience in a family practice residency program is required.

To apply, send letter, proof of board certification, curriculum vitae, bibliography and reference letters to:

Mercy Hospital Medical Center
Department of Medical Education
400 University Avenue
Des Moines, Iowa 50314

Mercy Hospital Medical Center and its facilities make up a 673-bed, Catholic, not-for-profit hospital founded in 1893. Mercy admits more than 25,000 patients each year with areas of excellence in heart, cancer, birthing and pediatrics, critical care, and emergency medicine. Mercy maintains 17 Des Moines-area primary-care clinics and a network of 14 rural hospitals. The Mayo Graduate School of Medicine, one of the largest medical residency and fellowship programs in the United States, is the sponsor of the Mercy/Mayo Family Practice Residency Program.

MERCY
HOSPITAL MEDICAL CENTER
400 University Ave. • Des Moines, Iowa 50314

General Faculty—The University of Iowa Department of Family Practice offers full-time faculty positions for residency-trained, ABFP certified family physicians. Obstetric skills and previous teaching experience highly desirable. Additional faculty needed to address new primary care initiatives. As a part of a full academic department, responsibilities include teaching, research and patient care. Well-established 24-resident program is university-administered, community-based and has admissions at community and university hospitals. A new model office facility is being built. Well-established department with special strengths in its clinical and behavioral science faculty. As a "Big Ten" university community, Iowa City is a great place to live. Appointment and salary commensurate with qualifications and experience. The University of Iowa is an Equal Opportunity/Affirmative Action Employer. Women and minorities are encouraged to apply. Submit a letter of interest and CV to Gerald J. Jogerst, MD, Interim Department Head, 2149 Steindler Building, Iowa City, Iowa 52242-1097; 319/335-8454.

General Surgeon, Dubuque, Iowa—BC/BE general surgeon needed. Join our well-established multispecialty clinic and enjoy referrals from 81 physician partners. Our clinic is physician owned and managed and we market our own HMO within a 45-mile radius of Dubuque. Our practice is located on the campus of a 330-bed hospital with a Level II trauma center and we have two university tertiary referral centers within 90 miles of Dubuque. Excellent income and benefits provide security and our community provides an exceptional lifestyle. Send CV to Denis Albright at Medical Associates Clinic, 1000 Langworthy, Dubuque, Iowa 52001 or call 800/648-6868.

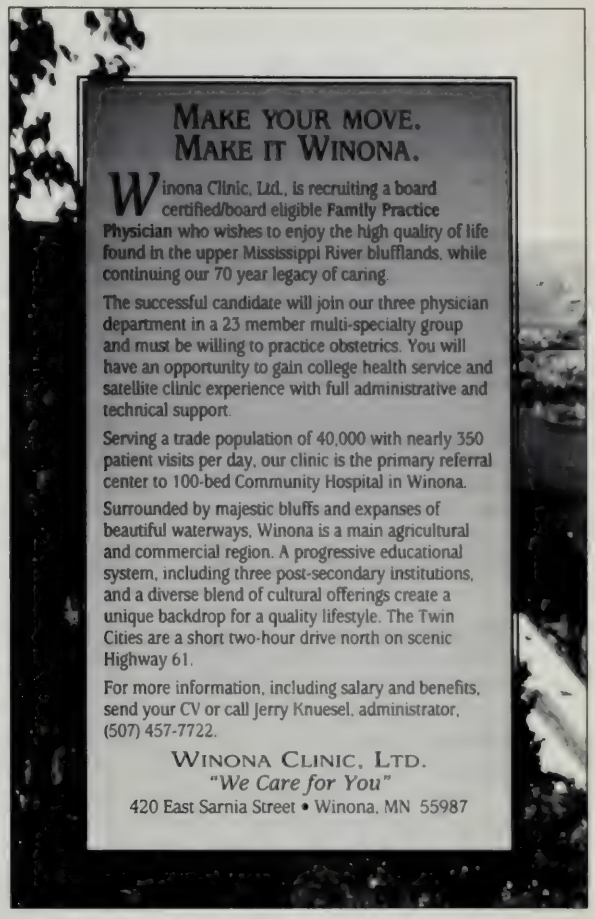
For Sale

QBC Blood Analyzer with centrifuge

$3500 or best offer
Call John
402/558-8585
to see or for more details

Internal Medicine and OB/GYN Practice Opportunities—Rural lake country community is seeking the above practitioners to join an active 12 (soon to be 14) physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquires to Lake Region Clinic, PC, Attention: Joel Rotvold, PO Box 1100, Devils Lake, North Dakota 58301 or call 800/648-8898 for further information.

General Surgery, Estherville, Iowa—Rural community of 7,000 people is recruiting a general surgeon. 58-bed hospital is well equipped and has 5-person FP group in the community and the full range of consultants who rotate through on a regular basis. Competitive financial package. Fabulous recreational opportunities available at nearby Spirit and Okoboji lakes. Solid work force. Good schools. Low crime area. For more information, contact Christopher Kashnig, Physician Recruiter, P.O. Box 1100, Oshkosh, Wisconsin 54902. Call 414/236-2430; fax 414/236-1312.



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1212 Pleasant, Suite 106
Des Moines 50309
515/243-0590
Allergy & Immunology

Allergy Institute, PC
A.Y. Al-Shash, MD
R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

Pediatric and Adult Allergy, PC
Veljko K. Zivkovich, MD
Robert A. Colman, MD
1212 Pleasant, Suite 110
Des Moines 50309
515/244-7229
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Dermatology

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Cedar Rapids 52403
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Fort Dodge Medical Center, PC
Carey A. Bligard, MD, FAAD
James D. Bunker, MD, FAAD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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John Milner-Brage, MD
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Waterloo 50702
319/234-6446
Electromyography & Nerve Conduction Studies
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Emergency Practice Associates
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1-800/458-5003
Specialists in Emergency Staffing & Emergency Department Services

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Daniel J. Schroeder, MD
Ravi K. Vemuri, MD
Infectious Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hours 515/224-1777

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Mid-Iowa Fertility, PC
Donald C. Young, DO
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
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Gastroenterology
Kenneth W. Adams, DO, AOBIM
General Internal Medicine
William C. Robb, MD
Richard H. Brandt, MD, ABIM
Grace Z. Ang, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurology

Iowa Medical Clinic Neurology
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Laurence S. Krain, MD
600 7th Street SE
Cedar Rapids 52401
319/398-1721
Neurology, EEG, EMG, Evoked Potentials and Sleep Studies

Fort Dodge Medical Center, PC
Jugal T. Raval, MD, MBBS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Neurosurgery

Iowa Medical Clinic
Neurosurgery
James R. Lamorgese, MD
600 7th Street, SE
Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
2710 St. Francis Drive, Suite 401
Waterloo 50702
319/232-8756; fax 319/232-5703
Practice limited to Neurosurgery

Robert Hayne, MD
Thomas A. Carlstrom, MD
David J. Boarini, MD
1215 Pleasant, Suite 608
Des Moines 50309
515/283-5760
Neurological Surgery

Des Moines Neurosurgeons, PC
Robert C. Jones, MD
S. Randy Winston, MD
Douglas R. Koontz, MD
2600 Grand Avenue, Suite 210
Des Moines 50312; 515/283-2217

Chad D. Abernathey, MD
1953 1st Avenue SE
Cedar Rapids 52402
319/363-4622
Neurological Surgery

Obstetrics/Gynecology

Fort Dodge Medical Center, PC
Brian L. Welch, MD
Earl R. Elowsky, MD
Timothy W. Neff, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Ophthalmology

Ophthalmic Associates, PC
Robert D. Whinery, MD
Stephen H. Wolken, MD
Robert B. Goffstein, MD
Lyse S. Strnad, MD
540 E. Jefferson, Suite 201
Iowa City 52245
319/338-3623

North Iowa Eye Clinic, PC
Addison W. Brown, Jr., MD
Michael L. Long, MD
Bradley L. Isaak, MD
Randall S. Brenton, MD
James L. Dummett, MD
3121 4th Street, S.W.
P.O. Box 1877
Mason City 50401
515/423-8861

Timothy F. Moran, Jr., MD
2800 Pierce, Suite 106
Sioux City 51104
712/252-4333
General Ophthalmology

Fox Eye Institute
Lee Birchansky, MD
Mario Mota, MD
510 10th Street, SE, Cedar Rapids 52403
1400 7th Avenue, Marion 52302
1-800/I SEE YOU

Wolfe Clinic, PC
Russell H. Watt, MD
John M. Graether, MD
Gilbert W. Harris, MD
James A. Davison, MD
Norman F. Woodlief, MD
Eric W. Bligard, MD
David D. Saggau, MD
Steven C. Johnson, MD
Todd W. Gothard, MD
309 East Church
Marshalltown 50158
515/754-6200

Satellite Offices
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6000 University Avenue, Suite 300
West Des Moines 50266
515/223-8685

804 South Kenyon Road, Suite 100
Fort Dodge 50501
515/576-7777

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-0103

214 - 13th Street Southeast
Cedar Rapids 52403
319/362-8032

Orthopaedic Surgery

Iowa Orthopaedic Center, PC
Marvin H. Dubansky, MD
Marshall Flapan, MD
Sinesio Misol, MD
Joshua D. Kimelman, DO
Timothy G. Kenney, MD
Lynn M. Lindaman, MD
Jeffrey M. Farber, MD
Kyle S. Galles, MD
Scott A. Meyer, MD
Cassim M. Igram, MD
411 Laurel, Suite 3300
Des Moines 50314
515/247-8400

Otolaryngology

Phillip A. Linquist, DO, PC
1000 Illinois
Des Moines 50314
515/244-5225
Ear, Nose and Throat Surgery, Facial Plastic Surgery, Head and Neck Surgery

Iowa ENT, PC
Thomas A. Ericson, MD
Marshall C. Greiman, MD
Steven R. Herwig, DO
Thomas O. Paulson, MD
Mark K. Zlab, MD
1-800/248-4443
1215 Pleasant, Suite 408
Des Moines 50309
515/241-5780

1200 35th Street, Suite 200
West Des Moines 50266
515/225-7761
Satellite Clinics:
Pella, Perry, Newton, Indianola, Oskaloosa, Guthrie Center, Lakeview Medical Park-West Des Moines

Wolfe Clinic, PC
Michael W. Hill, MD
Daniel J. Blum, MD
309 East Church
Marshalltown 50158
515/752-1566

Lakeview Medical Park
6000 University Avenue, Suite 310
West Des Moines 50266
515/224-9533

Sartori Professional Building
516 South Division Street
Cedar Falls 50613
319/277-3105
Otolaryngology–Head and Neck Surgery, Facial Plastic Surgery, Allergy

Robert G. Smits, MD, PC
1040 5th Avenue
Des Moines 50314
515/244-8152
1-800/622-0002
Ear, Nose and Throat Surgery, Facial Plastic Surgery and Head and Neck Surgery

(Continued next page)

Professional Listing Rates

Physician members of the Iowa Medical Society may advertise in this directory. Monthly rates are as follows: $10.00 first 3 lines; $2.00 each additional line. Billed yearly. May be prorated. Send or fax copy to Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265-3599, fax 515/223-8420.

Iowa Head and Neck Associates, PC
Robert T. Brown, MD
Eugene Peterson, MD
Richard B. Merrick, MD
3901 Ingersoll
Des Moines 50312
515/274-9135

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Thomas J. Benda, Sr., MD
James W. White, MD
Craig C. Herther, MD
Thomas J. Benda, Jr., MD
310 North Grandview Avenue
Dubuque 52001
319/588-0506

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319/351-5680
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1890 John F. Kennedy Road
Dubuque 52002
319/556-7542
fax 319/556-8334

Iowa Medical Clinic Outpatient Pain Treatment Center
James R. LaMorgese, MD, FACS, Neurosurgeon, Medical Director
Sandra Gannon, LSW, ACSW, Program Director
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Cedar Rapids 52401
319/399-2013
Neurology, Psychiatry, Anesthesiology, Rheumatology

Perinatology

Des Moines Perinatal Center, PC
Neil T. Mandsager, MD
3408 Woodland Avenue, Suite 302
West Des Moines 50266
515/222-3060
Maternal-Fetal Medicine
Routine and Advanced (Level II) Obstetric Ultrasound
Genetic Counseling
Amniocentesis and CVS
Antenatal Testing
High-Risk Obstetrical Management
High-Risk Deliveries

Physical Medicine & Rehabilitation

Genesis Regional Rehabilitation Center
Genesis Medical Center
1227 East Rusholme Street
Davenport 52803
319/383-1466
Maurice D. Schnell, MD
Fareeduddin Ahmed, MD
Arthur B. Searle, MD
Bogdan E. Krysztofiak, MD

Rehabilitation Medicine Associates
William D. DeGravelles, Jr., MD
Charles F. Denhart, MD
Marvin M. Hurd, MD
William C. Koenig, Jr., MD
Karen Kienker, MD
Todd C. Troll, MD
Lori A. Sapp, MD
Younkers Rehabilitation Center
Iowa Methodist Medical Center
1200 Pleasant
Des Moines 50308
515/283-6434

Pulmonary Medicine

Chest, Infectious Diseases & Critical Care Associates, PC
Roger T. Liu, MD
Steven G. Berry, MD
Donald L. Burrows, MD
Michael Witte, DO
Gerard A. Matysik, DO
Ronald L. Rains, MD
Pulmonary Diseases
1601 NW 114th, Suite 347
Des Moines 50325-7072
24 Hour 515/224-1777

Fort Dodge Medical Center, PC
Robert C. Ang, MD, FCCP
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Surgery

Wendell Downing, MD
1212 Pleasant Street, Suite 410
Des Moines 50309
515/241-5767
Diseases and Surgery of the Colon and Rectum

Fort Dodge Medical Center, PC
Ralph E. Woodard, MD, FACS
Dan P. Warlick, MD, FACS
800 Kenyon Road
Fort Dodge 50501
515/573-4141

Urology

Fort Dodge Medical Center, PC
Leland M. Coffman, MD
800 Kenyon Road
Fort Dodge 50501
515/573-4141

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Fear and opportunity

To quote a forgotten source, a sensitive man feels fear and a thinking man sees opportunity.

Proponents of capitation see it as a way of fixing costs for a specified time and shifting risk to the person responsible for the care of an insured. The proponents of capitation are also in control of the information that would allow responsible rate setting. Access to that information will allow reasonable negotiation of a capitated contract. At the Iowa Medical Society's recent conference "Organizing for Change", experts offered helpful advice on dealing with new payment arrangements.

What effect will capitation have on our daily practice? It depends on the level of risk you assume. If the primary care physician is capitated for the whole cost of patient care, the temptation will be not to refer to a specialist. We will need a new committee to establish guidelines for referral.

If the primary care person is capitated only for primary care and the specialist is fee-for-service, the pressure will be to refer very generously to a specialist.

If someone is tenured in a position, his or her work area of care responsibility is very narrow. The primary care person may find it difficult to get a specialist to take on a case, especially a difficult one.

Who will take care of the COPD (Chronic Obstructive Pulmonary Disease) patients? An anesthesiologist, a family practitioner, an internist or experts in pulmonary medicine, allergies, gerontology, may decide that certainly does not fall under their specialty.

There are many cases or procedures where specialties overlap. A cognitive doctor may find the proceduralist doctor can also discover ways to get rid of the hot potato. As we go from fee-for-service to capitation, what will our professional incentives be? Incentive to learn a new procedure or gain new knowledge is necessary for the health of our patients.

Anyone who has tried to catch a horse knows a carrot works better than a stick. Capitation will surely offer new temptations in our medical practices and should raise some interesting issues. I foresee whole new areas for new regulations and new committees. You will need to get on a committee to protect your area of interest or to get someone else to do the work.

We have an opportunity for closer cooperation between physician groups.

We have an opportunity to work toward closer cooperation between our physician specialty groups. Coordinated care to help our patients to a life of good health and peace of mind is a desirable goal. IM



James White, MD

IMS Update

The Iowa Medical Society has available a set of cassette tapes from the successful *Futures* conference "Organizing for Change". The tapes contain excellent presentations by experts in managed care issues. For more information on ordering a set of tapes, see page 522. Or, call Linda Tideback or Bev Corron at the IMS, 515/223-1401 or 800/747-3070.

AT A GLANCE

The American Medical Women's Association, Iowa Branch, is sponsoring a conference entitled "Women in Medicine: the Balancing Act" January 20-21 at the Embassy Suites Hotel in Des Moines. All women physicians, residents and medical students are invited to attend. CME credits are available. For more information, call Jane Winston, MD, 515/278-0949.

A second IMS dues mailing will be sent in mid-December. If you haven't yet paid your IMS dues, your prompt attention to this matter will be appreciated.

Updated copies of the IMS Articles of Incorporation and Bylaws *are available by calling Sandy Nelson at IMS headquarters, 515/223-1401 or 800/747-3070.*

IMS offices up for election in 1995

Offices up for election at the Iowa Medical Society's Annual Meeting April 29-30 at the Marriott Hotel include: (The length of each term is in parenthesis, along with the name of the physician now holding the office.)

PRESIDENT-ELECT (1) — Joseph Hall, MD, Des Moines
VICE PRESIDENT (1) — Siroos Shirazi, MD, Iowa City
TRUSTEE (3) — William McMillan, MD, Ottumwa
HOUSE SPEAKER (1) — Donald Kahle, MD, Dubuque
VICE SPEAKER (1) — Tom Throckmorton, MD, Spencer
AMA DELEGATES (2) — Clarkson Kelly, Jr, MD, Charles City
Daniel Youngblade, MD, Sioux City
AMA ALTERNATES (2) — Two open seats

Judicial Councilors are elected by a district wide vote of eligible IMS voting members. The names of physicians elected as Judicial Councilors will be submitted for confirmation by the 1995 House of Delegates. Details will be sent to county medical societies due to elect councilors in 1995. Up for election are:

District 1 — Robert Kent, MD, Burlington
District VI — John Justin, MD, Mason City
District IX — Jay Heitsman, MD, Ottumwa
District XIII — Linda Iler, MD, Lake City

IMGMA elects officers

Alice Eveleth, clinic administrator of the Estherville Medical Center, P.C., was elected president of the Iowa Medical Group Management Association (IMGMA) at the group's fall meeting October 13 at University Park Holiday Inn, West Des Moines.

Other officers and board members include Nancy Park, administrator of Marshalltown Medical Clinic, president-elect; Dick Clock, past president; Denise Chaffee, administrator of Family Practice Center, Cedar Rapids, secretary; Steve Hilpipre, treasurer; Julie Barto, administrator of Siouxland Women's Center, Sioux City; and Susan Lombard, administrator, Physicians Eye Clinic, West Des Moines.

IMGMA is dedicated to quality physician office management and has 550 members.

AMA federation study continues

The second meeting of a Consortium studying organized medicine at all levels was held in early October. The Consortium includes 160 members of county, state and specialty societies, the AMA and other organizations. Dr. John Rhodes, Jr. of Pocahontas represents IMS on the Consortium.

The group is studying ways to realign organized medicine to better meet the needs of physicians in the next century. Watch future issues of *Iowa Medicine* for updates on Consortium activities.

Specialty Society Update

The Iowa Oncology Society held its annual meeting October 28 at Mercy Hospital in Cedar Rapids. Roscoe Morton, MD concludes two years as the founding president of the society.

The Iowa Psychiatric Society will hold its spring meeting April 1, 1995 in West Des Moines.

The Iowa Society of Rehabilitation Medicine held its annual meeting October 21 in West Des Moines. Members discussed scope of practice and legislative issues.

The Iowa Association of County Medical Examiners (IACME) held their first education and business meeting October 28 in Ames. Attendees discussed timeliness of reports from the state DCI laboratory, affiliate memberships, a recent attorney general's opinion on county medical examiner employment status, insurance coverage and state legislative recommendations on cremation permits.

Focus on IMS Alliance

Many physician spouses have professions of their own in addition to caring for a family. This allows little extra time for another organization. However, the IMS Alliance is not just another organization. Its members have much in common and a deep understanding of the physician's role. The sole purpose of the Alliance is support of medicine's goals. Some of our members are directly involved in our projects and others support us through dues. All levels of involvement are welcome.

What if the Alliance didn't exist? The part of medicine that reaches out to communities, feels the pulse of the people, searches for needs to be filled and carries your message to the public would be missing.

As we begin our membership drive for the year, I have a few requests for you to consider:

1. Ask your spouse if he or she is a member of the Alliance. If not, ask why.

2. Encourage your spouse to learn more about what the Alliance does and what it means to be a member.

3. If your spouse is in a profession which has a support organization similar to the Alliance, join it.

4. Give an Alliance membership to your spouse for Christmas.

5. Have a very happy holiday season, knowing you have not only benefited your spouse and your profession, but the community in which you live.

Contributed by Barbara Bell, president of the IMS Alliance

Focus on spouse battering

In January and February, *Iowa Medicine* will examine the complex problem of spouse battering. Articles by representatives of many disciplines will focus on diagnosis and documentation of spouse battering, the effects of domestic violence on children, a profile of batterers, legal and liability considerations and other important issues. These special issues of *Iowa Medicine* are one component of a project initiated by the IMS Task Force on Domestic Violence, chaired by Rebecca Wiese, MD of Davenport.

The IMS project will educate physicians regarding their role as part of an interdisciplinary team working to solve this terrible problem. The task force is also working on production of an educational videotape, a handbook and patient education materials.

Don't miss these important issues of your magazine. IM

In January and February, *Iowa Medicine* will examine the complex problem of spouse battering.

The Iowa Medical Society Alliance Board of Directors and past IMSA presidents extend best wishes to you and your family for a happy holiday season!

AMA-ERF Holiday Sharing Card Contributors

Elaine Anderson
Jan Bannister
Barbara Bell
Dorothy Carpenter
Mary Conway
Ann Crouch
Julie Delperdang
Patti Dolezal
Cindy Ehrecke
Audrey Eklund
Lou Eversmann
Mary Jo Godwin
Hermina Habak
Marcia Heggen
Judy Hoenk
Martha Holzworth
Geni Howard
Karen Johns
Debbie Johnson
Mary Ellen Kimball
Joan LeValley
Adrianne Lugo
Maureen Lyons
Karen Messmer
Linda Miller
Sandy Miller
Patricia Minchin
Dianna Moeller
Elaine Olsen
Carol Rask
Mary Jo Rater
Gail Sands
Jeannine Schulze
Pam Smits
Diane Trimble
Charlene Ver Steeg
Erlene Veverka
Pam Waters
Marion Weyhrauch
Bonnie Zittergruen

Futures

AT A GLANCE

A program entitled "Telemedicine in Iowa: The Future is Now" has been scheduled for Monday, January 9 from 7:00 to 9:30 p.m. The origination site will be IPT-Studios in Johnston. Look on page 524 for more details.

About 1,000 doctors and a group of Iowa hospitals have formed a statewide health care delivery system. The Integrated Health Delivery plan will bring together Iowa Methodist and Iowa Lutheran Hospitals in Des Moines, University Hospitals in Iowa City and a network of 17 smaller hospitals affiliated with the Sisters of Mercy. The plan will be run by Blue Cross Blue Shield.

Cassette tapes available from IMS Futures conference

Over 100 Iowa physicians attended the Iowa Medical Society's "Organizing for Change" ***Futures*** conference October 27 in Des Moines. Attendees heard six excellent speakers discuss how the practice of medicine is changing and how Iowa physicians can meet the challenges of the new environment.

Here is a sampling of physician comments on feedback forms:

"The speakers were well-focused and authoritative. A high quality meeting."

"I wish all physicians could hear this program."

"Excellent hands-on information."

"Very high quality program. Keep them coming."

"Plenty of useful, practical advice. Almost too much to take in!"

"The speakers' level of knowledge and insight was impressive."

If you missed the "Organizing for Change" conference, you can still order a set of cassette tapes containing the entire day's program, including Dr. James Todd's entertaining and informative luncheon presentation. The cost of the tapes and related materials is $42.50. The set of cassettes without related materials is $26.25. To order, use the order form on page 534 or call Barbara Heck or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

Look on page 532 of this issue for a feature report on the highlights of expert presentations at the conference "Organizing for Change".



Over one hundred physicians from across Iowa attended the Iowa Medical Society's *Futures* conference "Organizing for Change" October 27. Attendees heard expert presentations on managed care issues and an informative and entertaining luncheon presentation by Dr. James Todd, executive vice president of the American Medical Association. This month's *Iowa Medicine* contains a feature story on the presentations.

The speakers you'll hear on our tapes

Speakers at the Iowa Medical Society's "Organizing for Change" conference represent a wide range of expertise in key aspects of planning for the future of medical practice.

Kenneth Davis, JD is an attorney in the government, health care and association practice group of Jenner & Block and is based in the firm's Chicago office. He has provided counsel for deals between physicians and hopsitals or management companies and has examined many physician contracts in Iowa.

William DeMarco is president and CEO of DeMarco Associates in Rockford, Illinois. He has 15 years of experience in marketing. His broad national exposure to employers' needs combined with his hands-on experience developing products and strategies, offers an up-to-date perspective on what employers want in health care today.

Ed McIntosh, JD is a partner in the Des Moines law firm of Dorsey and Whitney, where he represents physicians, hospitals and nursing homes in health, employment, regulatory and litigation matters. Mr. McIntosh is knowledgeable regarding integrated delivery systems in Iowa and Iowa law

regulating these systems.

TOM GOREY, JD is president of Policy Planning Associates in Crystal Lake, Illinois. A former AMA staffer, he has spoken before a variety of audiences on topics relating to delivery and financing of health care.

DAVID LYONS is director of the Iowa Department of Economic Development and chair of the Iowa Health Reform Transition Team. Mr. Lyons is well-versed in health system reform efforts in Iowa.

JAMES TODD, MD is a general surgeon and executive vice president of the American Medical Association. He is an excellent speaker and very knowledgeable in developments in Congress and in the future of organized medicine.

Local *Futures* program available

Are you looking for an informative program for your county medical society or hospital staff meeting? The Iowa Medical Society has available a program to help educate Iowa physicians about managed care issues.

The program, given by IMS staff, will be adjusted to fit the group's level of knowledge. The presentation will give a comprehensive overview of some of the forces causing drastic change in health care delivery and will serve as a basis for further discussion by groups of physicians. Program content can be adjusted to include information regarding CHMIS and other issues which will affect Iowa physicians in the future. Availability of the program depends on scheduling considerations.

For more information, call Barbara Heck or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

AMA also has managed care resources

The American Medical Association has available a number of resources for physicians interested in exploring their managed care options in the changing environment.

A GUIDE TO FORMING PHYSICIAN-DIRECTED MANAGED CARE NETWORKS — The AMA and the Texas Medical Association developed this excellent book, which provides a "how-to" approach to developing physician-led networks. This guide provides practical advice and strategies and is available to AMA members for $17.95 and to non-members for $26. Please call Jean Fagan at the AMA, 312/464-4802, for more information on ordering the guide.

DOCTORS' ADVISORY NETWORK — The AMA's Doctors' Advisory Network is a national network of managed care attorneys and consultants credentialed by the AMA. AMA members who call 800/AMA-1066 can receive referrals to qualified experts and a booklet entitled "A Physician's Guide to Selecting and Working with a Managed Care Attorney or Consultant". AMA members who have used this free service rate it highly.

DOCTORS' RESOURCE SERVICE — DRS was written for physicians and covers the range of managed care issues. It is an excellent in-depth managed care resource. Physicians can buy the entire series or selected issues. Call 800/621-8336 for more information.

THE LEGAL ADVISOR — This newsletter covers state-of-the-art in managed care and medical staff issues. It was rated as one of the AMA's best products in a recent survey. Each issue contains an in-depth feature article on a pressing managed care subject. To order, call 800/621-8335.

WHITE PAPERS — AMA's Office of General Counsel has developed a series of white papers on managed care issues, such as "How to Develop a Physician Organization". Copies of the white papers may be obtained by calling 312/464-5601.

PRINCIPLES OF MANAGED CARE AND GUIDELINES FOR CONDUCT OF MANAGED CARE — "Principles of Managed Care" contains all of the AMA's managed care policy. "Guidelines for Conduct of Managed Care" contains basic principles the AMA negotiated with CIGNA, the Blue Cross Association and HIAA. IM

NEED FUNDS FOR A PHYSICIAN VENTURE?

The AMA's Capital Pool Project, which the House of Delegates voted to support in June, facilitates formation of physician-driven ventures by helping physicians develop solid business plans and by identifying potential sources of financing. This new project has already received four applications for financing, one from a county medical society. For more information, call 800/AMA-1066.

Legislative Affairs

AT A GLANCE

Mark your 1995 calendars now for the Iowa Medical Society's Medicine Day at the Iowa Legislature, which has been scheduled for Wednesday, March 22. Iowa physicians and their spouses AND clinic managers will have an opportunity to visit the Iowa Statehouse and talk with their legislators. For more information, call Paul Bishop at the IMS, 515/223-1401 or 800/747-3070.

At least one of every five dollars given to congressional candidates by PACs and large individual donors comes from enemies of comprehensive health system reform, says the consumer group Citizen Action. The AMA was listed as a leading contributor in the group's report with $1,363,474 given to candidates during the past 18 months.

Telemedicine program January 9

IMS is a cosponsor of a program "Telemedicine in Iowa: The Future is Now" scheduled for Monday, January 9 from 7:00 p.m. - 9:30 p.m. The origination site will be IPTV studios in Johnston.

Intended for physicians, hospital administrators, clinic managers and nurses, the program will be interactive and provided over the Iowa Communications Network to various sites around Iowa.

Expert panels will discuss reimbursement issues in telemedicine, legal/confidentiality issues and technical issues.

The program is sponsored by the IMS, the Iowa Telemedicine Advisory Council, the Iowa Hospital Association, University of Iowa College of Medicine and other organizations.

Physicians taking part in the program are eligible for 2.5 hours of AMA Category I continuing medical education credit through the UI College of Medicine.

For more information, call Becky Roorda at the IMS, 515/223-1401 or 800/747-3070.

Self-employed may lose tax break

Several million self-employed Americans may be in for a rude surprise when they file their taxes next year. They will no longer be able to deduct any portion of the money they pay for health insurance, the Associated Press reported recently.

The 25% deduction for the self-employed expired at the end of 1993. Lawmakers in both parties expected to restore it and provide a more generous tax break as part of health reform.

Many health reform bills proposed giving the self-employed at least a 50% tax deduction, but all tax proposals died along with health system reform legislation.

As of press time, there was speculation the problem could be rectified by Congress early next year or by the "lame duck" Congress following the election.

PAC SPENDING IN IOWA

According to the *Des Moines Register*, the ten biggest spenders among political action committees this summer and fall have poured over $600,000 into statewide and legislative races.

1. Iowa State Education Association (teachers)	**$128,588**
2. Associated General Contractors of Iowa PAC	**105,417**
3. Taxpayers United (Iowans for Tax Relief)	**72,508**
4. Iowa State United Auto Workers	**64,300**
5. Realtors PAC	**62,852**
6. HELP (trial lawyers)	**54,621**
7. Iowa Industry PAC	**43,475**
8. IOWA MEDICAL PAC (physicians)	**41,085**
9. Norwest State PAC	**36,250**
10 Iowa Committee of Automotive Retailers	**36,238**

Victorious Ganske ready to begin work

Greg Ganske, MD, a Des Moines reconstructive surgeon, rode a national Republican tidal wave November 8 to unseat 36-year Democratic incumbent Congressman Neal Smith. The vote in the hotly-contested 4th District race was 53% - 47%.

"It was a long campaign, but the real work is just beginning," Ganske told IMS staffers the morning following the election. "I'm honored to have the confidence of the voters. It's a tremendous responsibility."

Ganske says the November 8 election represents a "significant shift" in ideology for American voters.

"People sent a message to Washington — we don't want a bigger government, overwhelming regulation and higher taxes."

At the top of Ganske's agenda will be issues he has talked about throughout his campaign: the national debt, welfare reform and crime. Health insurance reforms and tort reform will also be his focus. He hopes to be appointed to

the Energy/Commerce Committee, which deals with health care, insurance and agricultural issues.

Dr. Ganske said he spent much of election day catching up on medical paperwork.

"It was a bittersweet afternoon. I truly love to practice medicine but I will be a full-time congressman all week long."

IMPAC played key role in election

The Iowa Medical Political Action Committee (IMPAC) played a key role November 8, and compiled an enviable record of contributing to winning candidates.

In the Iowa Legislature, 125 seats were up for election; over 30 of those were open seats. In addition, every state executive office from the Governor to the Secretary of Agriculture was on the ballot.

IMPAC participated in 112 state races and all five U.S. congressional races. In state races, 103 of the 112 candidates to which IMPAC contributed were victorious. IMPAC contributed over $65,000 to 69 Republicans and 43 Democrats.

In congressional races, all five of the candidates who received IMPAC/AMPAC funds were winners, including Des Moines surgeon Greg Ganske, MD. Two physician spouses sought office in Iowa. Betty Grundberg, wife of Arnis Grundberg, MD of Des Moines, was successful in her re-election bid for House District 73. Kim Landhuis, a Fort Dodge Republican, lost her bid for the Senate District 7 seat by just four percentage points. She is married to Jesse Landhuis, MD. IMPAC contributed to both these candidates.

"Through IMPAC, Iowa physicians become a unified force for maintaining patient care through changes in the system," commented William Eversmann, MD, Cedar Rapids hand surgeon and IMPAC chair. "It is essential that physicians become members of IMPAC so this important process can continue."

Bicycle-motorcycle head injury symposium

There will be a Bicycle and Motorcycle Head Injury Symposium Tuesday, December 13 at the Iowa Memorial Union, University of Iowa. For more information, call John Lundell, 319/335-4458. IM

If Your Jeweler Is Not A Member Of

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Medical Economics

Medicare payments: how is Iowa doing?

Iowa does not fare as well as some other states in Medicare benefit payments per thousand Medicare enrollees, according to the latest data from HCFA.

During the fiscal year 1993, the total Medicare benefit payments coming into Iowa was $1.3 million for 469,081 Medicare enrollees.

However, for the same period, the state of Colorado collected $1.42 million in benefits for 396,453 Medicare enrollees.

For a complete state-by-state listing of Medicare benefits and Medicare enrollees, call Donna Bottorff or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

CHMIS is coming July 1, 1996!

The Community Health Management Information System (CHMIS), signed by Governor Branstad on April 4, 1994, is schedule to be phased in starting July 1, 1996.

This means on this date, all Iowa physicians and hospitals must submit claims electronically.

What is CHMIS?

The CHMIS concept was designed to 1) meet the health data needs of all users in the system; and 2) improve the efficiency of processing health related encounters. All data provided by claims submitted is stored in a central repository and access to the data is granted to various stakeholders.

Who will govern CHMIS?

The Governor has appointed a board to oversee all decisions made in implementing CHMIS. The board is comprised of two physicians, two hospitals, two insurers and six consumers. Dale Andringa, MD, Des Moines; and Beth Bruening, MD, Sioux City, are the physician representatives.

Physician on each CHMIS committee

The following committees operate under the direction of the governing board. Meetings of these committees are open to any interested physician. Watch future issues of *Iowa Medicine* for scheduling information.

The committee charge and the physician and clinic manager on each CHMIS committee are listed below:

QUALITY REVIEW ADVISORY COMMITTEE — William Langley, MD; Elie Saikaly, MD. Charged with ensuring the quality, validity and reliability of data collected in the CHMIS data base.

ETHICS AND CONFIDENTIALITY ADVISORY COMMITTEE — Charles Jons, MD; Edward Maahs and Donna Bottorff of the IMS staff. Charged with reviewing confidentiality issues and answering the question: *Who gets what?*

DATA ADVISORY COMMITTEE — William Bonney, MD; John Brinkman, MD; Amy Wehr. Charged with determining what questions need to be answered by the data, where to get data elements and how to integrate existing data bases.

COMMUNICATIONS AND EDUCATION — Laine Dvorak, MD; Thomas Evans, MD. Charged

AT A GLANCE

In a recent "60 Minutes" segment, Andy Rooney was critical of attorneys in the O.J. Simpson trial and of attorneys suing physicians. "The American Medical Association says 53,000 physicians were sued last year. I asked the American Bar Association how many lawyers got sued for malpractice and they said they don't keep track. You can bet it wasn't 53,000."

According to the Kiplinger Letter, *the most serious effort in years to control entitlement spending is being made by a bi-partisan commission headed by Senators Danforth and Kerrey. Medicaid and Medicare are among some 500 programs which will account for 58% of federal spending within 10 years. By the year 2013, entitlements and interest on the national debt will eat up ALL federal taxes unless something is done.*

PROHIBITION AGAINST SELF-REFERRAL WILL BE EXTENDED JANUARY 1, 1995 — CALL IMS FOR DETAILS

The prohibition against physician self-referral, previously applicable only to clinical laboratory services, will be extended to additional services as of January 1. These services include physical therapy, furnishing of durable medical equipment, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, prosthetic devices, home health services, outpatient prescription drugs and inpatient and outpatient hospital services.

IMS has a summary of the Stark II provisions on self-referral from OBRA '93. To get a copy, call Donna Bottorff or Linda Tideback at the IMS, 515/223-1401 or 800/747-3070.

with designing education programs for notifying stakeholders of the impact and benefits of CHMIS.

TECHNICAL ADVISORY COMMITTEE — Thomas Menzel, MD; Mark Purtle, MD; Julie Drews. Charged with addressing technical issues regarding methods of acquiring new and different data elements and providing expertise concerning systems available locally in Iowa.

IMS has CHMIS committee

The Iowa Medical Society has its own CHMIS committee that will meet frequently with physicians who are members of the state CHMIS committees. The September *Iowa Medicine* contained an article explaining CHMIS in more detail and the magazine will contain much more information in order to help physicians prepare for the July 1, 1996 implementation date.

IMS is scheduling local meetings around the state to provide up-to-date training on CHMIS. If you would like to schedule a meeting for your county medical society or hospital medical staff, call Donna Bottorff at the IMS, 515/223-1401 or 800/747-3070.

Anti-dumping provisions protect physicians

Under anti-dumping provisions, participating hospitals may not penalize physicians who refuse to authorize transfer of unstabilized patients with an emergency condition, according to information provided to the IMS from the Iowa Foundation for Medical Care.

All provisions of the anti-dumping statute apply to patients with an emergency condition or women in labor who request services at a Medicare participating hospital which has an emergency department. This includes freestanding clinics and emergency care facilities which are certified as part of a Medicare participating hospital which has an emergency department.

Medicare-participating hospitals must screen patients seeking treatment to determine if an "emergency medical condition" exists. (See definition in box.) If screening reveals an emergency condition, the hospital must provide further examination and treatment to stabilize the condition, or for transfer of the individual to another facility.

Transfer requirements

The hospital may not transfer the individual unless the individual requests transfer or a physician certifies the medical necessity of the transfer. If a physician is not present in the emergency department at the time the patient is transferred, a qualified medical person must sign a certification after consulting with a physician (who later signs the certification) stating that the benefits reasonably expected from provision of appropriate treatment at another facility outweigh the risks to the patient.

Participating hospitals with special capabilities (burn units, shock trauma units, etc.) may not refuse an appropriate transfer.

Penalties for physicians

A participating hospital may not penalize a physician who refuses to authorize transfer of a patient with an emergency condition that has not been stabilized. A physician is subject to a penalty of up to $50,000 per violation for failure to meet the anti-dumping requirements. IM

What's an emergency medical condition?

For purposes of anti-dumping regulations, Congress has defined "emergency medical condition" as: a condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual or unborn child in serious jeopardy; serious impairment to any bodily function; or serious dysfunction of any bodily organ or part.

In a pregnant woman having contractions, an emergency condition occurs when there is inadequate time to affect a safe transfer to another hospital before delivery or when the transfer may pose a threat to the health or safety of the woman or unborn child. For a psychiatric condition to be considered an emergency, it must meet the general requirements of an emergency condition as defined above.

Iowa physicians and data collection

Is your office ready?

This issue of *Iowa Medicine* contains the third of three special inserts on why physicians must become knowledgeable and involved in data collection systems such as the Health Employer Data Information Set (HEDIS).

This month's insert discusses ways every Iowa physician can become involved in data collection.

If you missed the first two inserts which appeared in the October and November issues of *Iowa Medicine*, call Donna Bottorff at IMS headquarters, 515/223-1401 or 800/747-3070.

Practice Management

AT A GLANCE

Congress has repealed an employer reporting requirement which was part of the Omnibus Budget Reconciliation Act, 1993. The measure would have required employers who sponsor group health plans to report various information to the HCFA Data Bank. Before being repealed, the requirement was set to go into effect January 1, 1995.

In a recent survey on prescription medicines, four of 10 Americans age 45 and older admit they: never fill the prescription written by the physician (14%); fill the prescription but never take the medicine (13%); take less than the prescribed amount (22%); or stop taking the medicine before they should (29%).

Watch for these education programs

Within the next few weeks, you will receive information regarding three important IMS Services educational programs. (See the box below for details on some course topics.)

MANAGEMENT EDUCATION PROGRAM (MEP) — This 12-month program is for physicians and clinic administrators. It covers major management topics and their applications in health care delivery. The program begins February 10, 1995.

MEDICAL BUSINESS SPECIALIST (MBS) — MBS is designed for medical office personnel. This certification program in the field of medical office business policies and procedures involves 10 classes.

MIDDLE MANAGEMENT INSTITUTE (MMI) — This 16-module program in three segments is under development. It is designed for new health care managers and supervisors and to sharpen the skills of experienced managers.

Don't miss critical year-end information

Many practices allow important things to fall between the cracks, according to *Conomikes Reports* newsletter. Some practices have lost revenue or spent unnecessary time back-tracking due to inadequate procedures for tracking contracts that have year-end requirements.

Conomikes recommends the following steps as part of a year-end financial review:

- Set up a meeting with your accountant or tax planner as soon as possible.
- Review the budget and compare performance with goals.
- Establish the 1995 budget so it can start January 1.
- List your sources and needs for cash for the next three months; plan for shortfalls.
- List your managed care contracts that have had any withholds applied in 1994 so an early request for refund can be made in 1995.
- Review EOBs from major payors to identify possible undercharged services.
- If non-participating with Medicare, evaluate the collection percentage for Medicare. If less than 90%, consider participating for 1995.

Flu season is here

According to the Iowa Department of Public Health, over the past six years Iowa has averaged 140 cases of confirmed influenza with nearly 54,000 cases of upper respiratory illness. The IDPH recommends people in several high-risk groups have a flu shot:

- People over age 65;
- Residents of nursing homes or other chronic care facilities;
- People with chronic heart or lung problems including asthma;
- Health care workers exposed to high risk patients.

UPCOMING WORKSHOPS FOR YOU AND YOUR PRACTICE

MEP course topics

- Organizational theory in a managed care environment
- Financial management
- Management control and budgeting
- Outcome based management

MBS course topics

- CPT-4 and ICD-9 Coding
- Health insurance overview
- Billing and collection systems
- Office safety and compliance issues

MMI course topics

- Introduction to supervision
- Interpersonal communication
- Problem identification and problem solving
- Conflict resolution

For more information on any seminar, call Mary Reinsmoen or Sherry Johnson at the IMS, 515/223-1401 or 800/728-5398.

Midwest Medical Insurance Company Focus on Risk Management

Handling patient complaints

Unresolved patient complaints are a frequent catalyst for malpractice claims, especially if something goes wrong in a patient's treatment.

Regardless of how minor a complaint may seem, all complaints deserve a prompt, professional response.

A formal complaint policy can help ensure appropriate action is taken on all patient complaints. A prompt response to a complaint can prevent dissatisfaction from developing into litigation.

Minimize the risk of making a patient angry enough to contact an attorney:

•Allow only the physician to discuss complaints about medical care.

•Make certain all staff know who is responsible for handling patient complaints and can direct patients promptly and professionally to that person.

•Record complaints on a complaint form to make sure they aren't lost or forgotten. Track the type and number of complaints so they can be monitored on a clinic-wide basis.

•Handle complaints professionally and respectfully. Don't become argumentative or defensive.

•Inform your professional liability insurance carrier of any patient complaints about treatment that include a request for compensation or threat of legal action.

For further information, contact Lori Atkinson, MMIC risk management coordinator, MMIC West Des Moines office, PO Box 65790, West Des Moines, 50265, 800/798-9870 or 515/223-1482.

A prompt response to patient complaints can prevent dissatisfaction from developing into litigation.

Your investment performance

NOTE: This article was written by Jerry Foster, CFP, of Retirement & Investment Advisors, Inc.

Achievement of your long-term financial goals is closely tied to your ability to accumulate assets. This process requires three key elements: you must exercise discipline; you must maximize tax advantages; and you must choose the proper investment categories for your savings.

A regular and systematic method of setting aside money for future use makes sense, and the impact of beginning this process early is powerful. The ability to utilize tax advantages will allow you to maximize the long-term growth of your assets. This is especially important in view of increasing tax rates.

However, how can we say that the choice of investment categories can play an equally important role? The choice of investment categories has, in the past, been viewed as an area of little consequence when considering long-term goals.

There is certainly no shortage of information and "experts" who supposedly help you accomplish your goals. There is, however, one sound method to use when planning your investment strategy. Studies have proven there are three key determinants that have an impact on how well your investment portfolio will perform. The three determinants are:

1) Product selection (whether you purchase Stock A or Stock B);

2) Timing (whether or not you buy or sell a particular asset at a given time);

3) Asset class selection (to what extent you invest your money in stocks, bonds or cash).

The most important of these three elements is class selection. Over 90% of total investment performance has been attributable to this factor. Product selection and market timing each amount to less than a 5% impact on the total performance of your investments.

What does this mean? Obviously, if we can accomplish 90% of our objective by successfully completing the asset class selection, there is questionable value in investing substantial amounts of time in product picking and market timing. This realization will prevent many physicians from wasting time and money on the latest investment fad.

Asset class selection is also an excellent way to minimize the investment risk with any given investment combination. IM

Newsmakers

AT A GLANCE

More than 100 physicians attended the IMS/AMA-sponsored conference "Organizing for Change" on October 27. See page 532 for speakers' remarks and a special message from Dr. James Todd, AMA vice president.

Iowa Department of Public Health Director Christopher Atchison was recently installed as president of the Association of State and Territorial Health Officials (ASTHO). ASTHO represents the public health agencies of the 50 states, District of Columbia and seven U.S. Territories and is engaged in a wide range of legislative, scientific, educational and programmatic issues and activities on behalf of public health. Mr. Atchison is the first state health officer from Iowa to serve as president and only the second non-physician to head the group in its more than 110-year history.

Awards, appointments, etc.

Dr. Lynette Lamp has joined Medical Associates Clinic in Elkader. **Dr. Jon Kerstetter,** emergency medicine physician at Finley Hospital, Dubuque, has joined a 30-day African relief committee to provide medical care to war-stricken areas near Burundi and Rwanda. Waterloo oncologist **Dr. Mukund Nadipuram** recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Covenant Medical Center. The Cancer Liaison Program is an integral part of the Commission of Cancer of the American College of Surgeons. **Dr. Lee Birchansky,** Cedar Rapids ophthalmologist, has been certified by the American Board of Eye Surgery in the subspecialty field of cataract and lens implant surgery. **Dr. Daniel McGrail,** infectious diseases, has begun practice in Cedar Rapids. **Dr. Joseph Compton** has joined Dubuque Internal Medicine. **Dr. James Merchant,** University of Iowa College of Medicine professor of preventive medicine and environmental health and internal medicine, has been named to the National Advisory Committee on Occupational Safety and Health. The committee advises the U.S. secretaries of labor and health and human services on occupational safety and health programs and policies. **Dr. Scott Schemmel** was recently selected for membership in the American Orthopedic Society for Sports Medicine, an international medical specialty association of orthopedic surgeons from the U.S., Canada, Europe and Asia.

New members (as of September 1994)

Ames
Jay Brown, MD, allergy/immunology
David Carlyle, MD, family practice
Aeneid Liang-Jiu Chen, MD, ob/gyn
Robert Graveline, MD, gastroenterology
Thomas Menzel, MD, general surgery
Phillip Schmid, III, MD, anesthesiology

Bettendorf
Myra Daniel, MD, family practice
Narinder Kumar, MD, pediatrics
Dennis Xuereb, MD, ob/gyn

Burlington
Anil Dhuna, MD, neurology

Carroll
Arthur Mardis, MD, diagnostic radiology

Cedar Falls
Neil McMahon, MD, general surgery

Cedar Rapids
Mark Barnett, MD, thoracic/vascular surgery
Craig Dove, DO, physical medicine/rehabilitation
Tork Harman, MD, anesthesiology
Arond Honick, MD, diagnostic radiology/family practice
Mary Morrow, MD, family practice

Correction

The names of the following physicians were inadvertently omitted from the 1994-95 IMS Membership Directory:

ARCHER, DAVID, MD **058**
MCCRARY-ROST CLINIC, PC **FP**
1800 MAIN ST
GOWRIE, IA 50543 515/352-3891
FAX 515/352-5422
Dr. Archer has been a member since 1987.

SILVAN, KATHLEEN P, DO **310**
MERCY DMM6 MEDICAL CENTER **FP**
4230 FLEUR DRIVE, SUITE 2
DES MOINES, IA 50321 515/285-0934
Dr. Silvan has been a member since 1989.

Deceased members

Thomas Board, MD, life member, pediatrics, Waterloo, died March 6 IM

HEALTH CARE DATA COLLECTION

by William Bonney, MD & Jose Angel, MD ***3rd*** *in a series*

HEALTH CARE DATA collection is already underway and is proceding with great momentum. However, physicians have the responsibility to guide the process, with the public's benefit in mind.

Who will control data collection and analysis?

Reimbursement through capitated and negotiated fees will continue, with less physician discretion than now. Relevant data will still come from claims and payments, so large health plans, employers and insurance companies will remain in the driver's seat.

So where will the physician fit into this scheme?

Quality of care assessment is based on treatment outcomes, best understood by health professionals. The public interest is best served if physicians and HMOs are chosen by insurers according to quality of care delivered. Health care reform must arise from scientifically valid data about long-term health.

Physician responsibility

1. Confirm data accuracy. Work with hospitals and insurance companies to draw valid, clinically relevant conclusions. Interpret results to the public.

2. Ensure that practice guidelines are based on treatment outcomes and measures of quality.

3. Insist that these guidelines and performance measures (not just capitated costs) be used by insurers to choose HMOs and physicians.

4. Point the way for health system reform based on measures of lifetime health in large population groups.

Physician input is critical. Iowa physicians know Iowa health trends. They can help guide data collection systems and reform.

Events for physicians

(For a key to abbreviations, see the data systems and sponsors table on the other side of this insert.)

● ***Telemedicine, Monday, January 9, 1995, 7:00 p.m.-9:30 p.m.***— Iowa Telemedicine Council will offer a program, "Iowa Telemedicine: The Future is Now," on the Iowa Communications Network (ICN). Viewing locations will be announced. Topics include telemedicine and fiber optic basics, legal and confidentiality issues and reimbursement for use of the ICN.

For more information contact Becky Roorda at the Iowa Medical Society, 800/747-3070.

● ***Qualitrac office computer software field test***—Using HEDIS 2.0 standards, Sunderbruch/Encompass has written PC software (Qualitrac) to allow physicians to respond to requests for data in the HEDIS specifications.

Sunderbruch/Encompass now invites interested physicians and their office staff to participate in a field test of Qualitrac.

For more information contact Elodie Opstead at Sunderbruch/Encompass, 515/223-2164.

● ***CHMIS education***—Under the Iowa CHMIS law, effective July 1996, all physicians and hospitals will submit and all payers will accept electronic claims in a single format, based in part on HEDIS 2.0 standards. Eventually there will be a new data repository, a potential future source of outcomes, quality and performance data.

Iowa Medical Society staff is prepared to make presentations to physician and clinic manager groups regarding CHMIS. Con-

Is your office ready?

Health care data can lead to improvement in health care delivery, an exciting opportunity for physician leadership.

This article lists ways to participate. Please see the first and second inserts (October and November issues of Iowa Medicine*) for more information about projects and organizations of interest.*

tact Donna Bottorff at the Iowa Medical Society, 800/747-3070.

● *Clinical evaluation of data*—In the near future there will be a number of committee or individual physician opportunities to participate in the clinical validation of data collection systems. These may be announced by organizations listed below or by the CHMIS board.

For more information the following people may be contacted: Donna Bottorff (IMS), 800/747-3070; Peg Mason (IFMC), 515/223-2930; Kathy Fliehler (Sunderbruch/Encompass), 515/223-2857 or Paul von Ebers (BCBS of Iowa), 515/245-4500.

● *NCQA National Report Card Project Conference, January 1995*—National Committee of Quality Assurance (NCQA) sponsors the Report Card Project, involving 21 insurance companies nationwide to evaluate the HEDIS 2.0 standards and other measures of performance. (See the second insert in the November issue of *Iowa Medicine* for details.) Iowa BCBS has surveyed its Alliance Select subscribers for this project.

NCQA will hold a national conference to review and evaluate all results to date.

For more information contact Ann Greiner, director of communications at NCQA, 202/662-8610.

● *Blue Cross Blue Shield of Iowa field test and evaluation*—Currectly under development and trial at BCBS are a number of data collection and analysis technologies. (Please refer to the second insert in *Iowa Medicine*, November 1994.)

Interested physicians are invited to participate in a test of these technologies and of BCBS electronic medical record software.

For more information contact Paul von Ebers, senior vice president of health care management at IASD, 515/245-4563.

Data systems and sponsors

ACG Ambulatory Care Groups (Johns Hopkins University)
APR-DRGs All Patient Refined DRGs (3M Health Information Systems)
CHMIS Community Health Management Information System
HCQIP Health Care Quality Improvement Program (HCFA)
HEDIS 2.0 Health Plan Employer Data and Information Set (NCQA)
HOI Health Outcomes Institute
IASD Iowa and South Dakota (BCBS merger 1992)
IHDC Iowa Health Data Commission
IMS Information Management System (JCAHO)
Medis Groups Measures (data structure) in MediQual software
MP Med Profile (expanded version of UB-92, HCFA)
MQIS Medicare Quality Indicator System (HCFA)
PMC Patient Management Categories (Pittsburg Research Institute)
Qualitrac Software based on HEDIS 2.0 and available now (IFMC)
SF36 Standard Form 36 patient questionnaire (Rand Corporation)
VP Value Profiler (Value Health Sciences)

● *Electronic patient record symposium, March 14-19, 1995, Orlando, Florida*—Medical Records Institute (MRI) has organized a conference, "Toward an Electronic Patient Record '95" at Disney World Contemporary Resort.

For more information contact MRI, PO Box 289, Newton, Massachusetts 02160, 617/964-3923.

● *Health Services Research*—HSR methods are the basis for much of the strategy in health data collection and analysis. The Institute for Quality Healthcare (IQH) will continue to offer periodic conferences in Iowa and send a monthly newsletter to every hospital.

For more information contact Charles Helms, MD, IQH, 319/356-8855.

Author credits and acknowledgements for this series of inserts

William Bonney, MD, Urology Department, University of Iowa Hospitals, chairman, Iowa Medical Society HEDIS 2.0 Committee

Jose Angel, MD, Iowa Clinic Internal Medicine, West Des Moines

Timothy Pella, administrator, Orthopedic Reconstructive Surgery Associates, Burlington

Douglas Wakefield, Perry Meyer, Kathy Fliehler, Trisha Kurtz, Peg Mason, Gail Meyer, Paul von Ebers

Post election outlook

What do the November 8 elections mean for Iowa physicians?

The election of an IMS member to congress is cause for celebration. Dr. Greg Ganske unseated longtime incumbent Representative Neal Smith. We hope Dr. Ganske's election will herald a new era of physician involvement in government at all levels.

Voters have demanded a change. After decades of Democratic control, both the U.S. House and Senate have Republican majorities. Republicans have a chance to show they can lead the country.

Such issues as crime, health system reform and balancing the federal budget do not lend themselves to simple solutions. It is impossible to test most political solutions in the scientific way new drugs and medical treatments are tested. There are always a multitude of confounding variables in any political solution.

Complex issues such as health system reform are difficult to address. New congressmen such as Dr. Ganske have their work cut out for them.

Leaders of the new Republican majority in Congress have a significantly different role. Being responsible for implementing a political agenda is different from the traditional minority party role of trying to prevent the majority party from enacting misguided initiatives. Democrats, too, will have adjustments to make as their role changes to that of "loyal opposition."

Changes have also occurred in the Iowa Legislature. The Republican party consolidated control of the House of Representatives in a landslide victory increasing its seats from 51 to 64. The Senate remains in Democratic control with a 27 to 22 split and one seat open.

The wide margin in the House means Republicans may have an easier time passing their proposals. Whether they will be able to convince the Senate to go along with what they pass remains to be seen. We may be looking at gridlock if the two houses can't work together.

Most medical issues do not split along party lines. However, relations between the two houses will affect even those issues.

It is too soon to tell whether we will see much activity on health system reform. Proposals which had bipartisan support last year, such as individual insurance market reforms, have the best chance of being enacted.

Republicans have a chance to show they can lead the country.

What does this mean to you? It means that smart legislators, regardless of political party, will listen to their constituents. This means you. Our lobbyists can only be truly effective when legislators know they represent people—voters—in their district.

Get to know your legislators. Call them now, even before the session starts. Offer to provide feedback and assistance on medically related issues. Ask to meet with them to discuss a few issues. Let them hear what you have to say. If you don't they may hear only the other side.



Becky Roorda

Becky Roorda is manager of public affairs at the IMS and has been involved in legislative affairs for 15 years.

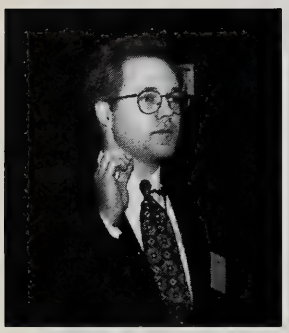
FUTURES

The future of medicine in Iowa

NOTE: This article is excerpted from presentations by guest speakers at the Iowa Medical Society's October 27 Des Moines conference "Organizing for Change". A set of cassette tapes containing the speakers' entire presentations is available from the IMS. An order blank appears on page 534.

"Be creative, but go into any arrangement with your eyes open, recognizing there are not going to be any absolute winners."

Excerpts of remarks by Ken Davis, an Illinois attorney specializing in health care. Mr. Davis discussed new directions being taken in health care delivery, the liability implications of managed care and managed care contract pitfalls to avoid.



KEN DAVIS, JD

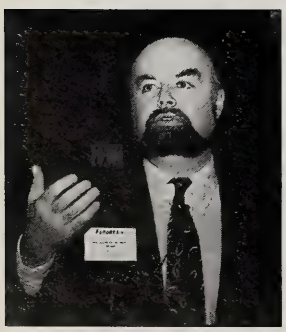
"In many parts of the country, fees are completely irrelevant. All that matters is the revenue you've got coming in and your cost of doing business. This means physicians have to do everything possible to reduce costs. Physicians criticize managed care companies because all they care about is price, but I believe we'll see a shift in focus from price to outcome. One of the reasons managed care companies haven't focused on outcomes is because the data just isn't there. This is the area where physicians have an opportunity to become involved and control the direction of health care delivery. Right now, we don't have a way to judge quality; but, people are trying to develop standards.

"Payers are becoming reluctant to ally themselves with PHOs because PHOs are, in some circumstances, fashioned to maximize hospital income. Payers view hospitals as a cost center and would rather ally themselves with physicians and let them manage the care and the dollars. What should you be doing? Do the best job you can to reduce the cost of practicing without sacrificing quality. Make yourself as attractive as possible to your 'customers' — your patients, referring physicians and payers.

"We need liability protection for doctors who are making cost-effective decisions. Right now, if you're in court and the plaintiff proves economics played a role in your treatment decision, you lose. In the future, patients could suspect the motives of physicians practicing in a capitated system. It will be extremely important to document and never deviate from the standard applicable to your practice. Advise your patients if you don't concur with the decision of a managed care company."

"You have to be able to negotiate with the big gorillas in the marketplace."

Excerpts of remarks by William DeMarco, a nationally-recognized expert in capitation and in what employers want in the competitive environment of managed care.



WILLIAM DEMARCO

"One physician I know said 'I'm so tired of people coming in and asking me, *Are you a preferred provider?* Just once, I'd like to say, *Yes, are you a preferred patient?*'

"Change is happening locally; what works for one part of Iowa won't work in another area. This is an evolving market and eventually, you will be forced to take sides. However,

E & M Coding

Surprising data for Iowa physicians

In 1992, the Health Care Financing Administration (HCFA) introduced the new Evaluation and Management (E & M) coding system for physician services in the office, outpatient sites, observation areas, hospitals, emergency rooms, nursing facilities and consultation services. The system was one part of Physician Payment Reform (PPR) and was intended to provide standardization of codes and code use throughout the country. The E & M Coding system was developed by the American Medical Association (AMA). Prior to its introduction, it was tested extensively by practicing physicians.

Ongoing education and training was provided by the Iowa Medical Society (IMS) and others to help physicians learn and use the new coding system appropriately.

On a national basis, HCFA is pleased with implementation of the new coding system. The predicted "behavioral shift" has not occurred and utilization patterns are as expected.

The IMS has been able to obtain HCFA's utilization data and study code utilization patterns in Iowa by specialties. Some specialty patterns closely parallel the national pattern; others do not. This raises interesting questions for Iowa physicians.

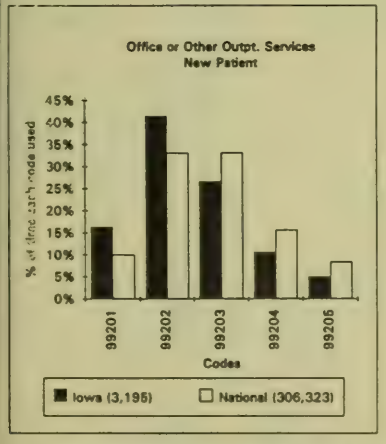
It seems unlikely that Iowa physicians are providing lower levels of service to their patients or that the Iowa Medicare population is comparatively less ill and needs less service than the Medicare beneficiaries across the nation.

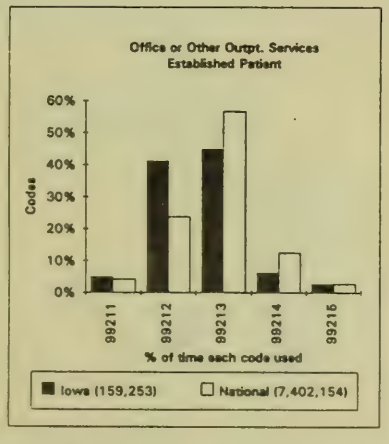
The following graphs display data on several of the larger specialties in Iowa for several of the E & M code ranges. This data is based on Medicare claims only for the first quarter of 1994. Total billed services for Iowa and the nation are shown for each code. Iowa data is displayed in black bars and national data in white bars.

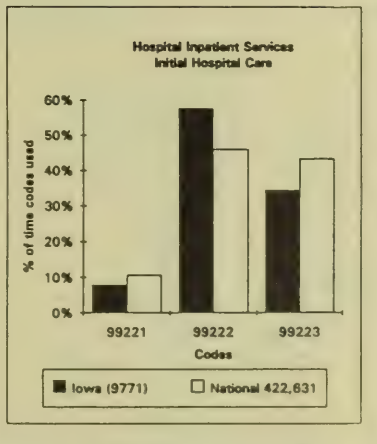
One goal of PPR was to redistribute Medicare funds to physicians providing primary care hands-on/cognitive services. Data shows Iowa physicians are not receiving the increased reimbursement from Medicare that was predicted (see story in December *Iowa Medicine's* Medical Economics section on page 526). The percent increase in Medicare payments per Medicare enrollee in Iowa from 1992 to 1993 was less than 5% while other states averaged 15% increases or more.

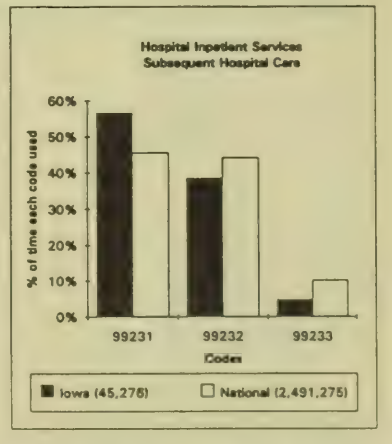
Iowa physicians will not receive more Medicare payment until they accurately bill for the services they provide to Medicare patients.

Family practice









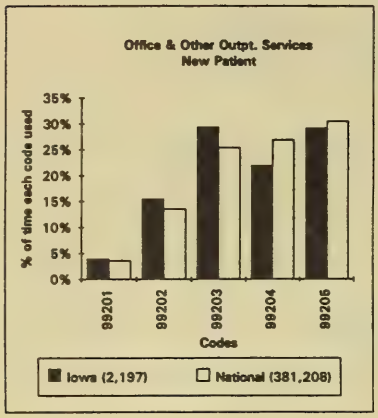
It is noteable that 57% of Iowa's new patient visits are codes 99201 and 99202 compared to 43% in the nation. These codes typically are for self-limited/minor or low/moderate severity presenting problems. Only 16% of Iowa's new patient visits are 99204 and 99205, the moderate/high severity presenting problem codes, compared to 24% in the nation. Established patient visits in Iowa are at the 99212 level 41% of the time compared to 24% in the nation. This code is for presenting problems that are usually self-limited or minor.

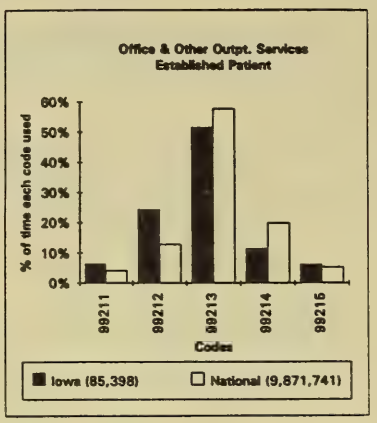
Hospital admissions are billed at the 99222 level 58% in Iowa compared to 46% in the nation. This code typically is for moderate severity problems. The high severity admission problems are usually billed as 99223 with Iowa using this code 34% of the time compared to 43% in the nation. Subsequent hospital care code 99231 is for patients who are stable, improving or recovering. Iowa uses this code 11% more than the nation. Code 99233 is for hospital patients who are unstable or have a significant new problem or complication. Iowa uses this code 5% of the time compared to 10% in the nation.

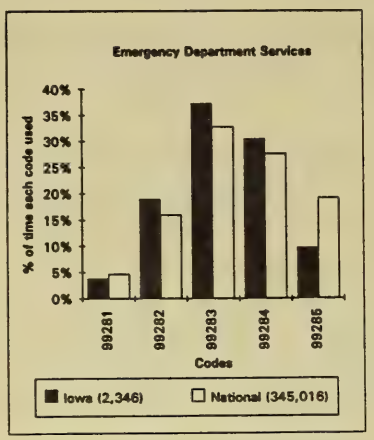
During this quarter family practice physicians used the office/outpatient consultation codes (99241-45) only 574 times. Since this is the appropriate code range for preoperative history and physical services, this volume seems extremely low.

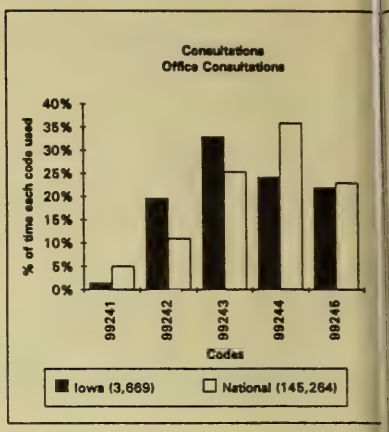
This information provided for Iowa physicians by the Iowa Medical Society

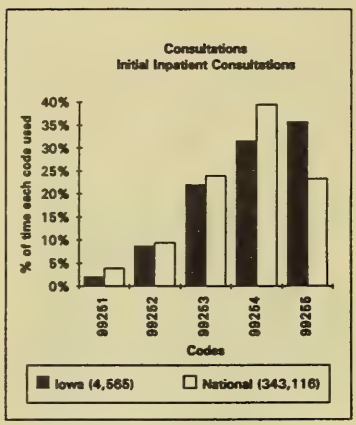
Internal medicine









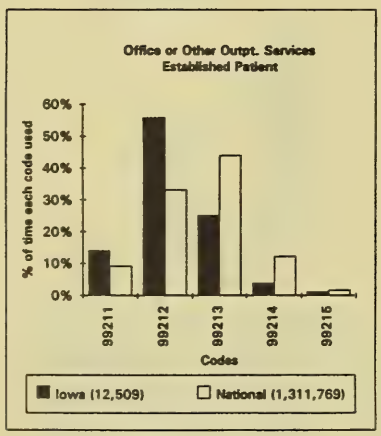


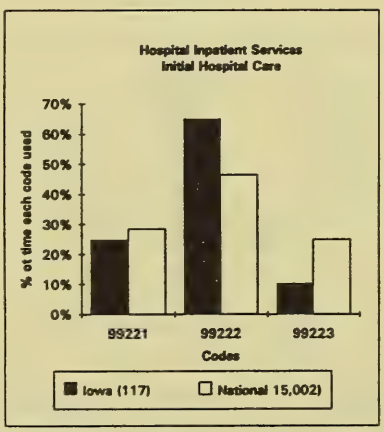
New patient office/outpatient code usage reflects national patterns quite closely, however for established patients, Iowa used the 2 lowest level codes 31% of the time compared to 17% in the nation. These codes are for minimal and self-limited presenting problems.

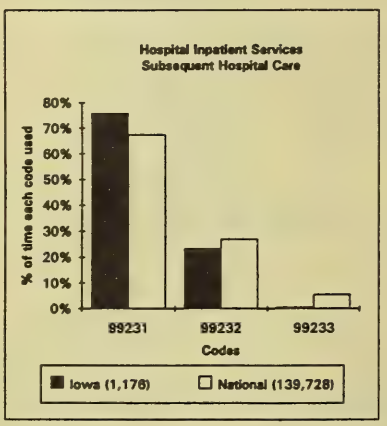
In the emergency code range (99281-85) the national data shows use of the 99285 code 19% while Iowa data is 10%. This code is for high severity problems with an immediate threat to life or physiologic function.

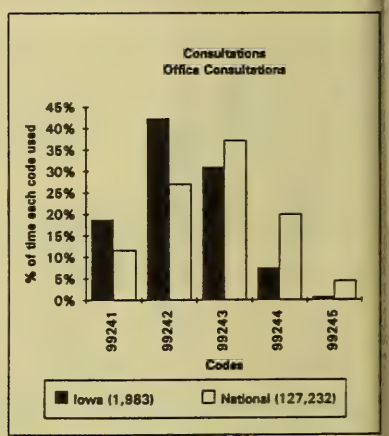
Office/outpatient consultation codes (99241-45) show a nearly even switch between Iowa and the nation in use of codes 99243 and 99244. These codes are for consultation on moderate/high severity problems. Inpatient consultation codes closely parallel the nation except the top 2 codes where Iowa uses the highest code 36% compared to 23% in the nation.

Urology









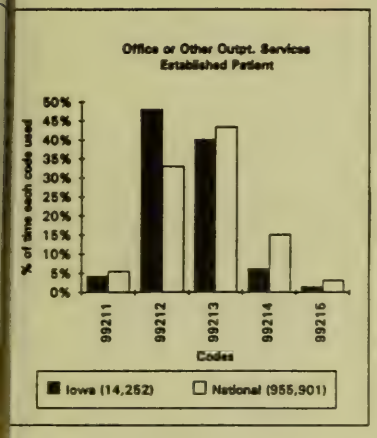
Iowa urologists use the 2 low level codes for office/outpatient services 70% of the time compared to 42% in the nation. These codes are for minimal, self-limited/minor presenting problems. Iowa uses the code 99213 for low/moderate severity presenting problems 25% compared to 44% in the nation.

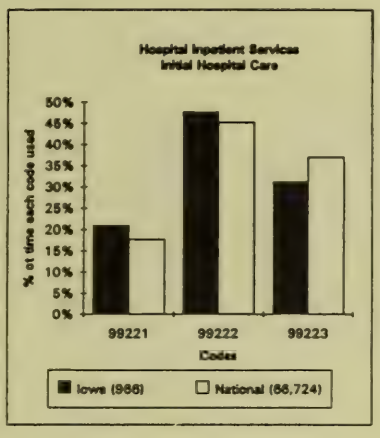
Initial hospital admissions are billed with the 99222 code 65% in Iowa compared to 47% in the nation. This code is for admissions with moderate severity presenting problems. Subsequent care codes (99231-33) parallel the nation closely.

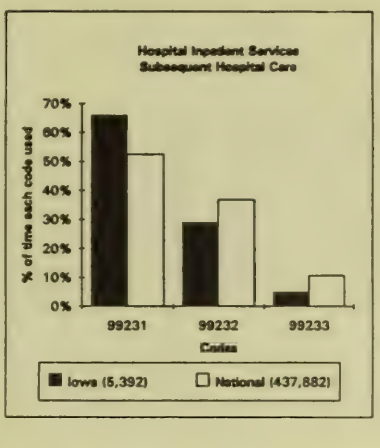
Office/outpatient consultation codes 99241-42 are used 61% in Iowa compared to 39% in the nation. These codes are for self-limited/minor and low complexity presenting problems. Code 99244 for moderate/high severity problems is used 7% in Iowa compared to 20% in the nation.

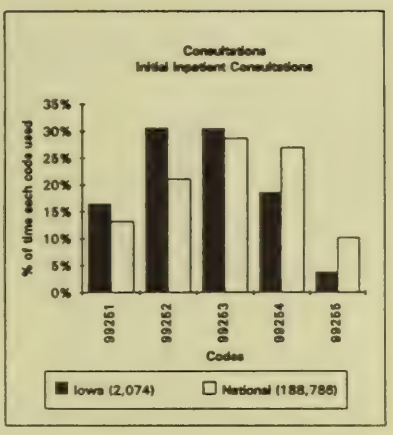
This information provided for Iowa physicians by the Iowa Medical Society

General surgery







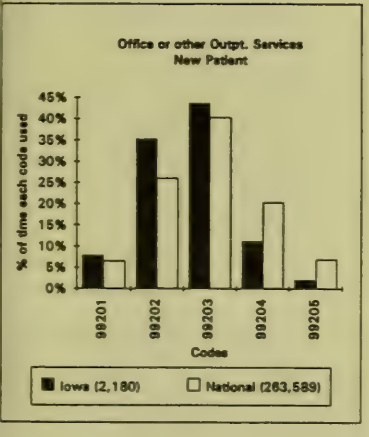


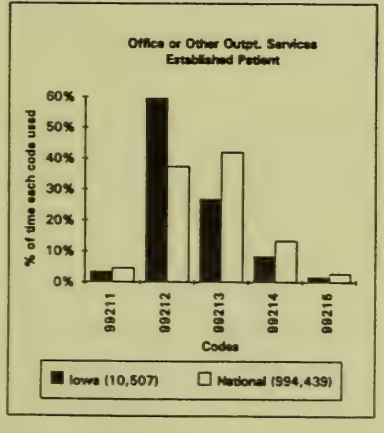
Code 99212 is used 48% of the time in Iowa compared to 33% in the nation. This code is for self-limited/minor problems. Code 99214 for moderate/high severity problems is used 6% in Iowa compared to 15% in the nation.

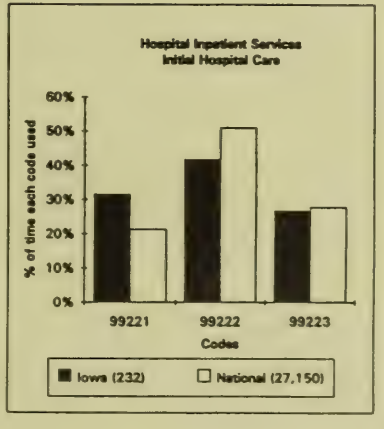
The hospital subsequent care code 99231 for patients who are stable, improving and recovering is used 66% of the time in Iowa compared to 53% in the nation. Code 99232 for patients who have developed a minor complication or are responding inadequately to therapy is used 29% of the time in Iowa compared to 37% in the nation.

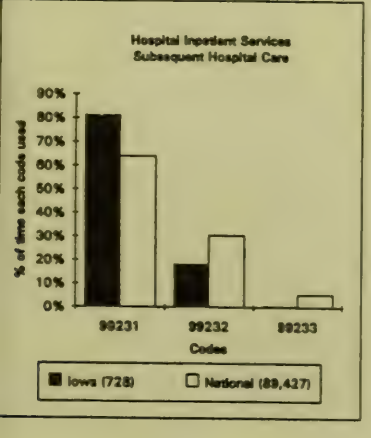
Iowa data shows that the 2 lower level inpatient consultation codes are used 47% of the time while the nation uses them only 34%. The 2 highest level codes are used 22% in Iowa compared to 38% in the nation. These codes vary based on the severity of the presenting problem.

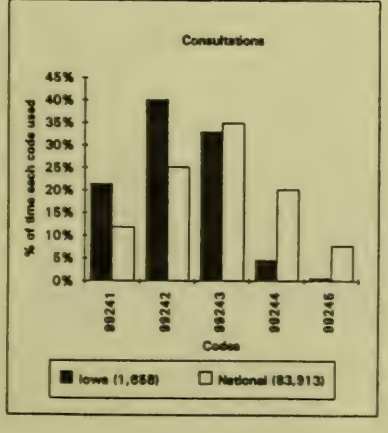
Orthopaedic surgery

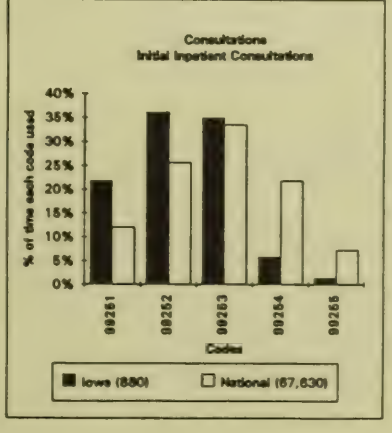






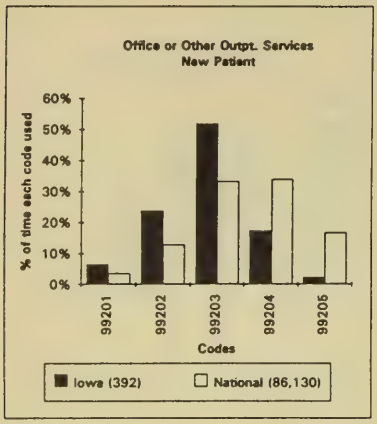


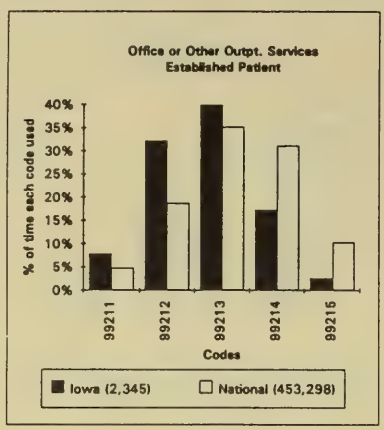


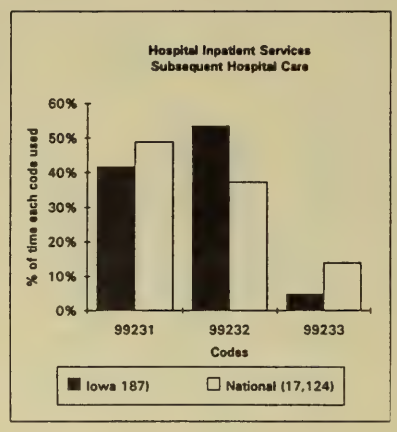


In the office/outpatient code range for new patients (99201-205) Iowa orthopaedic surgeons appear to use code 99202 for low/moderate presenting problems almost 10% more that the nation (35% vs. 26%). They use code 99204 for moderate/high severity presenting problems almost 10% less than the nation (11% vs. 20%).

In the established patient office/outpatient code range Iowa uses the 99211-212 codes 63% compared to 42% in the nation. These codes are for minimal, self-limited/ minor problems. Code 99213 for low/moderate severity presenting problems is used 27% of the time in Iowa compared to 42% in the nation.







New patient office/outpatient visits are billed at the 2 low level codes (99201-202) 30% of the time in Iowa compared to 16% in the nation. These codes are for self-limited/minor or low/moderate severity presenting problems. The nation uses the top 2 codes (99204-205) 50% of the time compared to Iowa's 20%. These codes are for moderate/high severity problems.

In the established patient office/outpatient code range (99211-99215) Iowa uses the 99212 and 99214 codes almost exactly opposite the nation.

Subsequent hospital care code 99233 for significant new problems or complications and unstable patients is used 5% in Iowa compared to 14% in the nation.

How can physicians use this data?

The E & M code utilization data raises interesting questions for Iowa physicians. Should Iowa's use of the codes more closely parallel the nation? Are there clinical explanations for significant differences from national peer groups?

Physicians must be sure they are choosing the correct E & M code—the code that reflects the service they provided their patient. They must adequately document the level of service in the medical record (see January *Iowa Medicine* article on the new HCFA Documentation Guidelines). The code billed should be for the level of service provided and documented. Codes should not be altered to compensate for concerns about coinsurance payments or patient account balance amounts. Billing and collection policies can be established to handle those situations as the physician directs. Physicians should not "down code" to avoid third party payor hassles. If correct codes are selected and documented they should be billed confidently. Unwarranted hassles can be addressed through the IMS and other organizations.

When correct codes are used the national data can be a useful comparison for an individual practice's internal monitoring. If your utilization pattern varies, you can investigate and make necessary changes or feel confident the variation is appropriate. Colleagues and partners can compare their individual coding patterns, seeking to understand differences and adjust their code selection if warranted.

The message is not to up code . . . the message is to code appropriately. The IMS is available to assist members in using the E & M data. First quarter 1994 data is available for most HCFA physician specialties (see list at right). Some specialties in Iowa have low volume data which is too small to be significant, but national data is available. IMS staff is available for presentations on correct E & M coding, implementing and analyzing internal auditing systems and the new HCFA documentation guidelines for E & M codes. Data and assistance can be obtained by contacting Mary Reinsmoen at IMS Services, 515/223-1401 or 800/728-5398.

HCFA physician specialty list

Allergy/Immunology
Anesthesiology
Cardiac Surgery
Cardiology
Colorectal Surgery (formerly Proctology)
Dermatology
Diagnostic Radiology
Emergency Medicine
Endocrinology
Family Practice
Gastroenterology
Geriatric Medicine
General Practice
General Surgery
Hand Surgery
Hematology
Hematology/Oncology
Infectious Diseases
Internal Medicine
Intervention Radiology
Medical Oncology
Nephrology
Neurology
Neurosurgery
Neuropsychiatry
Nuclear Medicine
Obstetrics/Gynecology
Ophthalmology
Orthopedic Surgery
Osteopathic Manipulative Therapy
Otolaryngology
Pathology
Pediatric Medicine
Peripheral Vascular Disease
Plastic and Reconstructive Surgery
Physical Medicine and Rehabilitation
Preventive Medicine
Psychiatry
Pulmonary Disease
Radiation Oncology
Rheumatology
Surgical Oncology
Thoracic Surgery
Urology
Vascular Surgery

it's not the structure which makes a venture successful, it's the physicians' ability to join together to make it successful. Managed care companies don't know which doctors to contract with. If you approach them with proposed improvements in quality — less time off work and less medical expense for employees — you'll have an open door with any large employer. If health plans don't form partnerships with physicians — if they treat physicians as vendors — they're doing it wrong. Physicians have much more clout than they realize. There is a tremendous rebirth in physicians moving to the top of the food chain.

"Whatever you've heard about capitation, it's all true and it's all false. Many physicians don't like to discuss capitation because they think it's all financial, but it isn't. Capitation is a change in the way you practice. Under capitation, you're accepting a greater share of the risks and a greater share of the rewards. Don't be a vendor, be a partner. Three years from now, you'll have clout because you'll be able to tell the employer how well Mrs. Johnson's treatment worked."

"Remember, there is a way to look out in the parking lot, see no cars, but still be making money. If a managed care entity is not bringing you volume, why sign with them?"

All over the United States, there is a tremendous rebirth in interest in physicians moving to the top of the food chain.

"Hospitals have been a driving force in rural Iowa because of the small number of physicians"

Excerpts of remarks by Ed McIntosh, a Des Moines health care attorney. Mr. McIntosh discussed integration in Iowa and what physicians risk by joining — or not joining — a PHO.

"The largest integration movement in Iowa is hospital mergers. There is a trend toward these hospitals — as clinic systems — to employ primary care based physicians. This trend will continue. Buyer coalition activity is beginning to drive integration in Iowa. The buyers want outcome data to control cost and there's a recognition that smaller, independent

continued next page

AMA leader predicts 'public backlash' against managed care

James Todd, MD, the executive vice president of the American Medical Association, told Iowa physicians at the "Organizing for Change" conference this is "the best of times and the worst of times" for physicians.

"We can do more for our patients than ever, but gone are the days when the physician was the true captain of the medical ship. Now, we have strangers at the bedside. At a time when we have to be organized to be effective, we find that trying to organize physicians is like trying to herd cats."

Dr. Todd also discussed why no health system reform emerged from Washington, D.C. Because Congress took no action, he said, reform is occurring "in the worst possible manner — quickly, frantically, with everyone trying to beat everyone else. Mistakes are being made."

"Throughout the debate, the AMA maintained a steady, firm strategy which has kept every door open to us. There is no table at which the AMA does not have a seat, unlike the groups who jumped on one plan or another and were never heard from again." The AMA will continue working for tort reform and patients' freedom of choice during future debates.

"I believe when the American public sees what is happening to their freedom of choice, there will be a public backlash against managed care. Physicians will have to be prepared to show society which way the pendulum needs to swing."

Dr. Todd's complete speech is contained in the "Organizing for Change" tape set available for sale.

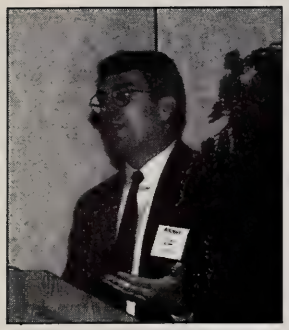
FUTURES

providers could be shut out of the market except for Medicare and Medicaid. As these programs move toward integration, some providers could also be frozen out of these markets.

"As an example, an employer coalition has formed in the Des Moines-Ames area with 20,000 potential enrollees and includes HyVee, Pioneer, Midland Savings, Norwest, Allied Insurance and others. This employer group is now controlling the Des Moines market and sent out requests for providers to respond to their demands.

"The next large system being developed is a consortium of the Blues, University of Iowa Hospitals, Iowa Methodist and Iowa Lutheran in Des Moines and Mercy hosptials in Dubuque, Sioux City, Mason City, Clinton and New Hampton. They will be able to offer a product throughout the state. This group is well-funded.

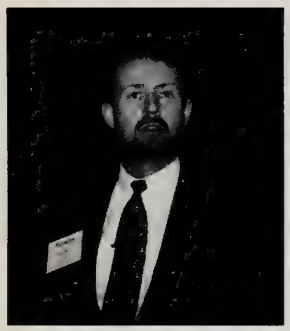
"Another major trend here is development of PHOs. In rural Iowa, financial resources for POs must come solely from physicians, so hospitals have been the driving force in developing PHOs. There are risks to joining a PHO and there are risks associated with not participating. Experience in other places shows that patients, after one year of paying a higher premium or deductible to see a physician outside a plan, begin to focus on cost and move toward the cheaper provider."



ED MCINTOSH, JD

"A consultant is anyone who calls himself or herself a consultant"

Excerpts of remarks by Tom Gorey, president of a health care consulting firm providing services to physicians. Mr. Gorey discussed how to find the right consultant for your project and how to get the most from them.



TOM GOREY, JD

"The extreme changes taking place in physicians' environment are driving a need for outside assistance. Managed care companies and hospitals are accustomed to hiring outside professional help; physicians are just beginning to get used to it. You can get help with strategic planning, managed care contracting, development of POs, practice mergers and valuation and information systems development. A consultant is anyone who calls himself or herself a consultant. Your best source of information is colleagues who have used consultants.

"As managed care makes further inroads in Iowa, having a good information system will be critical to the success of any PO." IM

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The Journal
of the Iowa Medical Society

Optimal LT_4 dosage in primary hypothyroidism

● *Udaya Kabadi, MD*

It is well-documented that the optimal daily dose of levothyroxine (LT_4) in replacement therapy of primary hypothyroidism varies widely. Studies suggested the wide range of LT_4 daily dose may be attributed to aging, associated chronic disorders or medications used to manage these disorders.[1-6] It is also likely that the etiologic factors responsible for induction of primary hypothyroidism may influence optimal daily LT_4 dosage, although data is lacking in the literature. This study examines the role of pathogenetic causes in the optimal daily LT_4 dose in primary hypothyroidism.

Searching for optimal dose

A population of 186 subjects, 152 men and 34 women, with primary hypothyroidism (age range, 25 to 84 years) attending an endocrinology clinic from June 1980, to June 1988, were studied. All patients were followed as outpatients during visits to the endocrinology clinic.

Patients were administered levothyroxine sodium (Synthroid, Flint Laboratories, Deerfield, Illinois) as the replacement therapy, with the objective of finding the optimal dose required to achieve euthyroidism irrespective of body weight. The initiating dose was 100 μg/day in patients under 50 years old who had no history of I_{131} therapy and/or surgical treatment for hyperthyroidism, external radiation therapy to the neck and/or neck surgery for nonthyroidal causes and ischemic coronary artery disease.

Patients 51 to 65 years old with no history of ischemic heart disease began therapy with LT_4 (50μg/day) because of the potential presence of subclinical ischemic heart disease. The same initial LT_4 dose was also used in younger patients in whom hypothyroidism was secondary to treatment of hyperthyroidism or radiation and/or neck surgery for other causes.

In patients with known ischemic heart disease as well as those over the age of 65 years, the initial daily dose of LT_4 was 25μg. Patients were examined at intervals of two to four weeks in the endocrinology clinic. In patients with initial dose of LT_4 of 50μg and 25μg, the dose was increased by 25μg every two weeks in the absence of chest pain, tachycardia and exertional dyspnea, until a dose of 100μg was reached or until patients were clinically euthyroid.

In all patients, serum levels of T_4, triiodothyronine (T_3), T_3 resin uptake and TSH were determined during each follow-up visit. The dose of LT_4 was adjusted until the basal TSH level normalized (<8mU/L). At this juncture, serum TSH concentration was determined after an overnight fast and again at 30 and 60 minutes after an intravenous bolus administration of 400μg of thyrotropin-releasing hormone. The LT_4 dose was adjusted depending on the TSH response to thyrotropin-releasing hormone administration.[3,8] The LT_4 dose was considered optimal when the basal TSH and TSH response (△TSH, 5-25m U/L) to intravenous thyrotropin-releasing hormones were within normal ranges on two successive visits at intervals of four of six weeks.[8]

Test results

One hundred and five subjects were diagnosed as having autoimmune thyroid disease, as defined by antimicrosomal or antithyroglobulin antibody titer of greater than 1:100. Of these, 45 subjects were classified as

The IMS Education Fund has designated this article as the Henry Albert Scientific Presentation Award for December 1994.

Udaya Kabadi, MD
Dr. Kabadi formerly practiced at the VA Medical Center in Des Moines. He is now chief of the Endocrinology Section at the VA Medical Center in Phoenix, Arizona.

Optimal LT_4 dosage in primary hypothyroidism

continued

having Graves' disease, since hypothyroidism had followed surgery and/or therapy with I_{131} for hyperthyroidism. The remaining 60 members of this group were labeled as patients with Hashimoto's thyroiditis, since they did not manifest previous symptoms of hyperthyroidism and were not treated with either surgery or I_{131} therapy. Thirty-one subjects were hypothyroid as a result of neck surgery and/or radiation therapy for cancer of the larynx or tongue or for Hodgkin's disease.

Six subjects were classified as manifesting drug-induced hypothyroidism. The remaining 44 subjects were grouped as idiopathic, since the test results for antithyroid antibodies were negative and no other known cause could be established. Subjects with Hashimoto's thyroiditis were the youngest whereas those with idiopathic hypothyroidism were the oldest.

Serum T_4 level was lowest in the group with Hashimoto's thyroiditis and highest in the subjects with drug-induced hypothyroidism; with intermediate values in the remaining groups. However, the lowest serum T_3 concentration was noted in subjects with prior radical neck surgery and/or radiation therapy for non-thyroidal malignant disorders while the group of subjects with prior treatment for hyperthyroidism with I_{131} and/or subtotal thyroidectomy manifested the highest levels. The remaining groups including subjects with Hashimoto's thyroiditis showed intermediate serum T_3 values. Furthermore, maximally elevated serum TSH concentration was observed in the group with Hashimoto's thyroiditis; the least elevated level was noted in the idopathic group with intermediate TSH concentrations being evident in the remaining groups. Finally, T_3 resin uptake values were not significantly different in individual groups.

Mean optimal LT_4 dosage was the least for subjects with idiopathic hypothyrodism and highest for subjects with Hashimoto's thyroiditis (see Table 1). Dosages in the remaining groups were significantly smaller than noted for a group with Hashimoto's thyroiditis. However, no significant differences were noted for the LT_4 dosages amongst these groups. Although the actual daily dose varied in individuals, the most extreme variation was noted in subjects with previously treated hyperthyroidism. The duration of LT_4 therapy required to achieve euthyroid state ranged between seven to 25 weeks in an individual. However, the duration was significantly longer in subjects with prior neck surgery and/or radiation for non-thyroidal malignant disorders, drug induced hypothyroidism and idiopathic variety when compared with subjects defined as Hashimoto's thyroiditis. No significant correlations were noted between the duration of therapy on one aspect and any of the thyroid function tests on the other.

TABLE 1
RANGE OF DOSAGE AND DURATION OF LT_4 THERAPY*

Group	No. of subjects	Mean LT_4 dose	Dosage range	LT_4 Rx weeks
I	60	146 ± 13	125-200	10 ± 2
II	45	119 ± 9†	25-175	12 ± 3
III	31	122 ± 6†	75-125	16 ± 4‡
IV	6	125 ± 9†	100-150	17 ± 4‡
V	44	116 ± 4†	75-125	17 ± 5‡

**A mean daily LT_4 [μg/day] range of dosage and duration of LT_4 therapy [LT_4 Rx] required to achieve euthyroid state in 186 subjects with primary hypothyroidism divided into groups according to etiology.*
†Significantly different from group I; $p < 0.01$.
‡Significantly different from group I; $p < 0.05$.

Pretreatment TSH concentration

The optimal daily LT_4 dose in primary hypothyroidism is influenced by associated chronic disorders and/or medications consumed.[4] The LT_4 dose may be predictable prior to initiation of replacement therapy by pretreatment TSH concentration.[13] Also, LT_4 dose varies according to the etiology of the disorder. It is apparent that maximum LT_4 dose is required by the hypothyroid population with Hashimoto's thyroiditis. Subjects with idiopathic hypothyroidism need the smallest daily LT_4 dose, and others the intermediate dosage.

The maximum dosage required by subjects with Hashimoto's thyroiditis may be attributed to the severity of the disorder as reflected by the lowest mean serum T_4 concentration and maximally elevated mean serum TSH level noted in this group. Significantly smaller LT_4 dosage in the remaining groups may be a reflection of the severity of hypothyroidism as documented by significantly lower TSH concentrations.

However, other individual factors may also

play a role. The presence of an associated chronic disorder and the concurrent effect of the non-thyroidal illness (Hodgkin's disease or cancer) causing anorexia, weight loss and wasting may contribute to the smaller LT_4 dosage as well as the lowest T_3 levels seen in subjects with radical neck disection and/or neck radiation.[4,14] Similar LT_4 dosage as well as thyroid function tests in idiopathic group may also be attributed to the age of these subjects as well as the presence of associated disorders.[1-4,13]

Mean lower LT_4 dosage noted in subjects with previously treated hyperthyroidism with I_{131} and/or thyroid surgery, when compared with subjects with Hashimoto's thyroiditis, may reflect the extreme variance of LT_4 dosage in individuals [25-175μg], dependent on the size of the remnant autonomously functioning thyroid tissue. Similar finding is documented in a recent study.[15] It is likely LT_4 dosage in an individual subject may be related to the time of I_{131} therapy or surgery and the onset of hypothyroidism, i.e., longer the duration, the greater the destruction of the gland, the lesser the functioning remnant and the higher the LT_4 requirement.

Finally, the lower LT_4 dose noted in drug-induced hypothyroidism may be secondary to an abnormality induced in one or more of the steps in thyroid hormone synthesis and release since thyroid tissue is apparently still intact and not reduced as in other etiologic forms of hypothyroidism. Although the duration of LT_4 therapy required to achieve euthyroid state appears to vary, it may be truly a reflection of the LT_4 replacement schedule used in the protocol according to the age as well as the presence of heart disease and other associated disorders.

It is apparent the etiologic factor responsible for induction of primary hypothyroidism may be another useful index of daily optimal LT_4 dosage in addition to the pretreatment serum TSH concentration.[13] The etiologic factor also seems to contribute to the variability of the thyroid function tests noted in subjects with primary hypothyroidism.

References

References noted in this article are available from the authors or the editors of *Iowa Medicine*.

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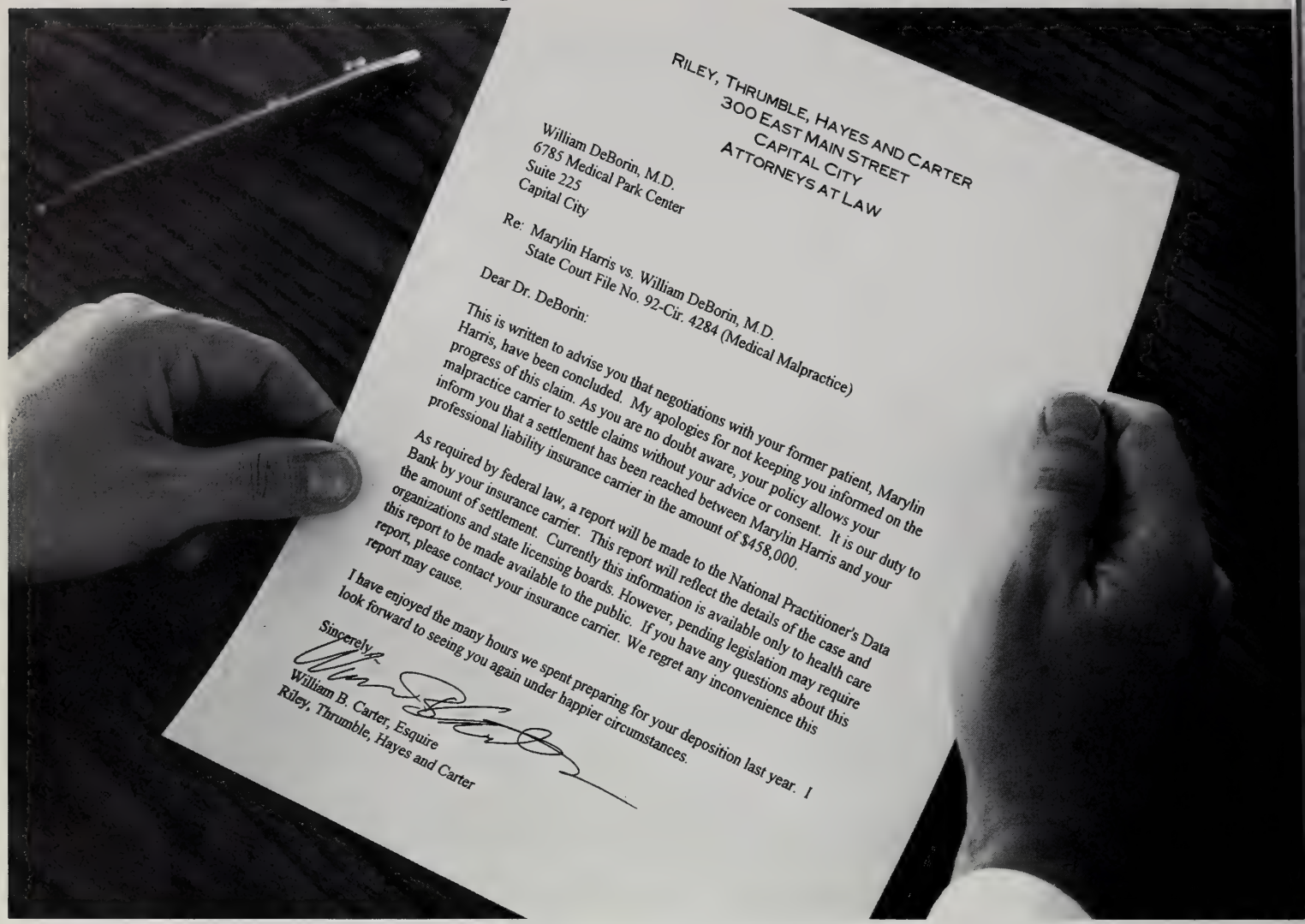
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Cynicism or realism?

The difference between cynicism and realism can become confusing. It is necessary to confront the true meaning, of these terms. In its fullest meaning realism is a "preoccupation with fact . . . and rejection of the impractical and visionary." Reality is defined further as "something that is neither derivative nor dependent, but exists necessarily." To be cynical implies "having a sneering disbelief in sincerity or nobility; to be contemptuously distrustful of human nature and motives." The cynic believes human conduct is motivated wholly by self-interest. The realist relies on fact, truth and verification.

Emerson stated "a cynic can chill and dishearten with a single word." Oscar Wilde in *Lady Wintermere's Fan* defines a cynic as "a man who knows the price of everything and the value of nothing". Henry Stimson averred "the only deadly sin I know is cynicism".

Ralph W. Stockman felt that "in being realistic we do not always have to be pessimistic"; while Jean Jacques Rousseau pronounced that "the world of reality has its limits; the world of imagination is boundless. Not being able to enlarge the one, let us contract the other; for it is their difference that all the evils arise that render us unhappy".

Some time ago I read a columnist who said we have become a nation of cynics—people who will believe anything so long as it is bad. Cynicism has been directed toward minorities, the poor and the ever-increasing tide of immigrants into our borders. It is not necessarily cynical for the public to express concern about what transpires within our communities. If the facts verify the presence of a problem, that is reality.

To express concern about the inability of some of our politicians to alleviate many of the ills of our society is not cynical. Though the conclusions drawn are disturbing and pessimistic, there remains a recognition of reality. If something appears real, proves to be real, it must be real. Realism becomes fact. To recognize that is not to be cynical.

As we come to the end of another year, we reflect upon the events of the past. Turmoil and social problems of crime, violence, the homeless and disjointed families are real. We cannot be complacent, nor can we be cynical. The new year will present many dilemmas. There will be soul-searching by some, laying blame by others, false accusations and misguided reactions by many. Yet we must face reality and, without cynicism, work to make our society strong. To use an old cliche, our efforts must be of the people, by the people and for the people. IM

If something appears real, proves to be real, it must be real.



Marion Alberts, MD

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Conflict of interest in CME

In 1992 the federal Food and Drug Administration drafted a policy document that sent planners of CME programs scurrying. The FDA decided to develop regulations to govern the commercial support of CME activities, asserting its jurisdiction over the issue by defining commercial support as a marketing strategy used by pharmaceutical companies to influence physician prescription practices. In part the FDA was responding to well-publicized abuses of the commercial support of CME, cases in which pharmaceutical funds apparently supported lavish recreation for CME participants at events of marginal educational value.

The FDA paper, still in draft form, stimulated a massive response by the national CME accrediting body, CME providers and pharmaceutical companies. The fiscal relationships of granters and program planners have formalized, legal agreements replacing letters of understanding. The accrediting body developed standards for providers of CME programs with commercial support.

Most physicians who participate in CME are sensitive to conflict of interest.

An element of these standards requires CME presenters to disclose any financial relationship the presenter may have with a company supporting the CME program which has the potential to create a conflict of interest. For example, a physician who has received funds to participate in the clinical trial of a new drug may be asked by the planners of a CME event to speak about the therapy of a condition utilizing that drug. The presenter, convinced of the efficacy of the drug based on the results of the clinical trial, may recommend the use of the drug during the CME presentation.

The disclosure by the presenter of participation in the clinical trial does not necessarily compromise the objectivity of the presentation, but permits the participant to more fully assess the conclusions of the presenter. The participant can evaluate whether the expertise of the presenter is derived from a broad understanding of therapeutic options or appears to stem primarily from the funded clinical trial. The comprehensiveness of the presentation reinforces objectivity. The presenter has the responsibility to convince the CME audience that his or her conclusions are not compromised.



Richard Nelson, MD

Disclosure in this context sounds somewhat intimidating. How have presenters responded? By most accounts there has been full cooperation. Most physicians or other professionals who are asked to participate in CME programs are sensitive to conflict of interest and are committed to maintain their integrity in discussing the efficacy of drugs or products, even when they have played a major role in the clinical evaluation of the agent or device.

Ultimately, the "consumer" of CME must be the judge of whether conflict of interest is at issue. The disclosure mechanism enables the CME participant to do just that. IM

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Mark was previously employed by the Iowa Medical Society as manager of specialty services.

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(Continued next page)

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Family Practice, Fairfield, Iowa—Over $140,000 package for the first year. Three board certified family physicians and physician assistant seeking 1 to 2 family physicians to join them. Progressive town of 10,000 in southeast Iowa. Recent large addition to clinic building. Seven million dollar addition remodeling of the hospital. Moving costs, student loan repayment, excellent salary, pension and benefits offered with no building buy-in required. Contact Fairfield Clinic, 304 South Maple Street, Fairfield, Iowa 52556; 515/472-4141.

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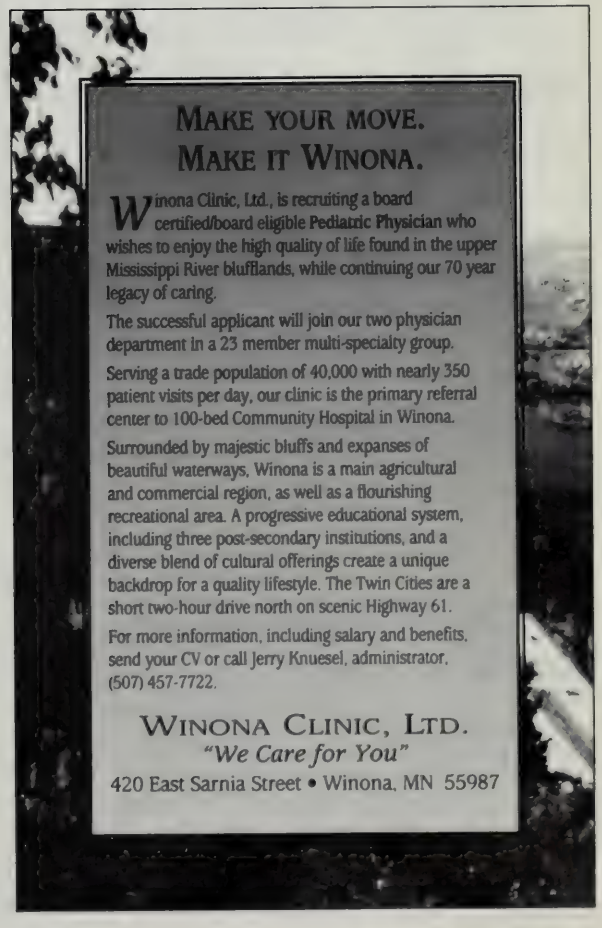
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Allergy & Immunology

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R.K. Agarwal, MD
1701 22nd Street, Suite 201
West Des Moines 50266
515/223-8622

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Robert A. Colman, MD
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General Internal Medicine
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Laurence S. Krain, MD
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Fort Dodge 50501
515/574-6845

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Cedar Rapids 52401
319/366-0481
Practice limited to Neurosurgery

Hosung Chung, MD
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Waterloo 50702
319/232-8756; fax 319/232-5703
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2561

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Des Moines 50312; 515/283-2217

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Bradley L. Isaak, MD
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James L. Dummett, MD
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P.O. Box 1877
Mason City 50401
515/423-8861

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Sioux City 51104
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Cedar Rapids 52403
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Donna J. Bahls, MD
Jill R. Meilahn, DO
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Des Moines 50314
515/247-8400

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Fort Dodge 50501
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fax 319/556-8334

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